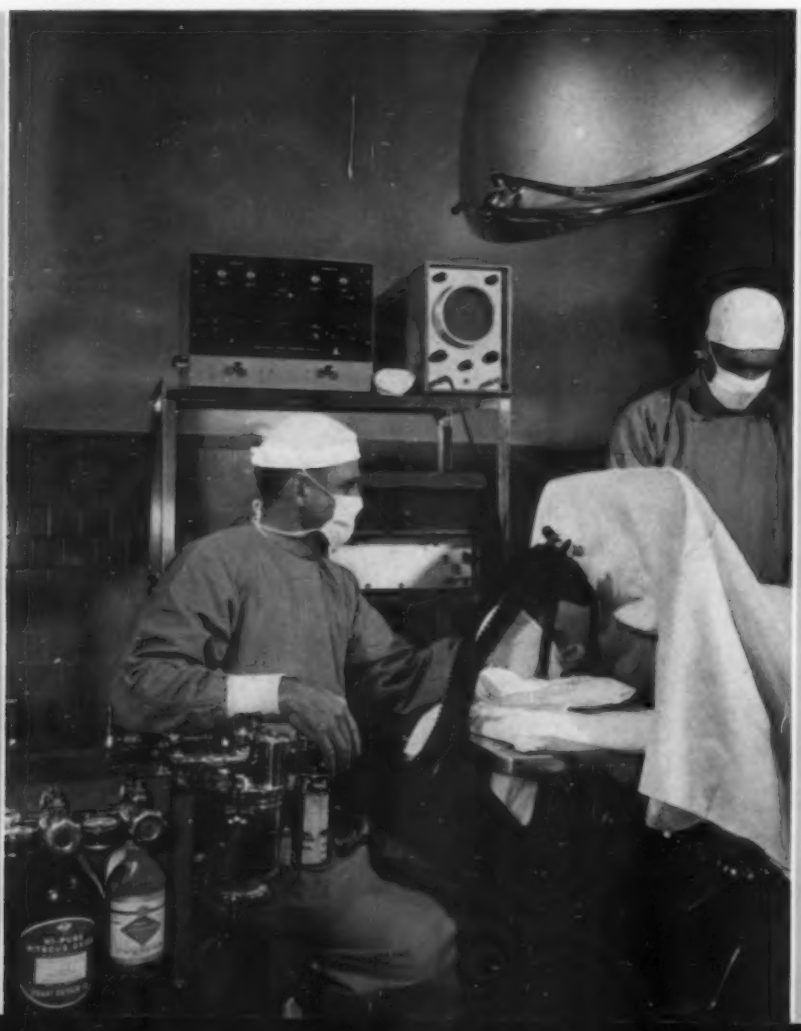
The Modern Hospital

JUNE 1958

ANESTHESIST IN OPERATING ROOM AT PALO ALTO HOSPITAL, PALO ALTO, CALIF. (See page 55)



how to turn those COMPLAINTS about room temperatures into *Bouquets!*

A 60-Hospital Survey* Shows Room Temperatures a Major Source of Patient Discontent. Here's the Remedy.

* * *

Of 49 deficiencies in care noted by patients themselves, only 4 outranked poor thermal conditions as sources of patient dissatisfaction!

The same study spotlights the nurses' side of the problem. Of 50 defects surveyed, staff nurses mentioned only 4 as occurring more often than "patient's room too chilly or too warm."

The simple answer to this serious problem of both patients and nurses is a Johnson Pneumatic Temperature Control System with *individual room* control. With a thermostat in every room, each patient gets the benefit of the exact "climate" he prefers or his physician specifies. What's more, he has one less reason to call for service, for the thermostat on the wall takes care of his comfort needs right around the clock.

Results: satisfaction all the way around... better care, better patient morale, more time for nurses to do their *real* job. And, a very realistic and substantial saving on heating and cooling costs!

The specialist Johnson organization has installed the pneumatic temperature controls in a majority of the nation's leading hospitals. When you build, modernize or expand, a nearby Johnson engineer will welcome the opportunity to demonstrate to you, your consulting engineer or architect, the unmatched efficiency and economy of a Johnson System. Johnson Service Company, Milwaukee 1, Wisconsin. Direct Branch Offices in Principal Cities.

* Study of patient care co-sponsored by U. S. Public Health Service, Division of Nursing Resources, and the American Hospital Association.

JOHNSON CONTROL

PNEUMATIC SYSTEMS

DESIGN • MANUFACTURE • INSTALLATION • SINCE 1885

The Modern Hospital

JUNE 1958 VOLUME 90, NO. 6

Articles in this issue

Continued on next page ►

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The Modern Hospital

MEDICINE AND PHARMACY

FOOD AND FOOD SERVICE

MAINTENANCE AND OPERATION

HOUSEKEEPING

REGULAR FEATURES

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THE PHYSIOLOGIC PLASMA ELECTROLYTE

Provides ionic concentrations of sodium, chloride, calcium and magnesium precisely as found in human plasma . . . the potassium concentration is twice that of normal plasma and bicarbonate is also provided in twice its plasma concentration in the form of metabolizable precursors, acetate and citrate.

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Because of the unique balance of its components, PLASMA-LYTE promotes normal fluid and electrolyte balances without inducing potassium toxicity, tetany or metabolic acidosis.

HOW SUPPLIED: Bottles containing 500 ml. and 1000 ml.

Where protein-sparing effect and increased caloric infusion are indicated, specify

PLASMALYTE with Travert® 10%

Bottles containing 500 ml. and 1000 ml.

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SCIENTIFIC PRODUCTS DIVISION GENERAL OFFICES • EVANSTON, ILLINOIS

READER OPINION

Let's Help Others

Sirs:

By a decision of the nursing committee at our hospital, the uniforms of some 60 student nurses were changed and we had no use for at least 200 pink dresses and an equal number of Hoover aprons.

Likewise, the medical staff decided to change a procedure and some items came to the purchasing department as "item no longer in use."

A study was instituted to decide which rubber glove should be purchased. Samples from all manufacturers, and dealers, were collected (and paid for). One glove was selected; what happened to the other gloves?

A manufacturer decided that a different label would be required on a certain package; the salesman came, picked up the old packages and replaced them with new stock. It is well known in manufacturing circles that the cost of reprocessing some items is higher than the cost of producing a new item. What happens to these items?

Until my eyes were opened, we used to "junk" these unwanted items and some manufacturers did the same thing.

My ideas concerning this procedure were changed when my wife and I were unfortunate enough to be in an automobile accident in one of the Virgin Islands and we were taken to a clinic for treatment. I went into the operating room while my wife was taken care of by the doctor. "Prepping" was done with a single edged razor blade; no handle was available. A broken tipped syringe was used for irrigating the wound; no irrigating syringes were available. Suturing was done with ordinary sewing cotton—wound on cardboard; no surgical silk was available. The needle used for suturing would not fit the suture. The doctor asked for four zero catgut; one zero was supplied. They only had a few tubes of 0 and 00 sizes.

Why this lack of common supplies? Because there was no money available to buy necessary items. This episode brought to mind the nurses' uniforms still in storage at home. One of our associates mentioned that the hospitals in the Indian country were very poor. We wrote to five mission hospitals, explaining what we had to donate to them. Four of the five replied they wanted what we could spare and would pay the transportation charges. The fifth wanted what we had to offer but could not afford the transportation. Needless to say, all five of the hospitals received these items.

Almost every hospital subscribing to this magazine has, I am sure, supplies it is not using. Every manufacturer of surgical supplies is in the same predicament. Let's change our disposition of these items so that a hospital, clinic or a mission in the South, in the islands of the Caribbean, in the Indian country of the Northwest, can utilize, and therefore patients can benefit from, supplies which now are being discarded.

I would be very glad to act as a clearinghouse, receiving names of needy hospitals or clinics, and also receiving lists of equipment and supplies available for these places. With this information I could bring the donor and recipient together.

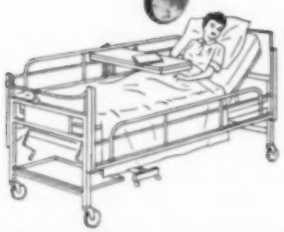
J. H. Wallace
Purchasing Agent

Grace-New Haven Community Hospital
New Haven, Conn.

THE MANY-PURPOSE BED
THAT FILLS ALL YOUR NEEDS

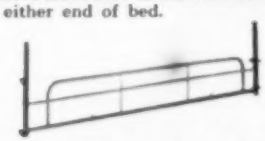
HARD
RECOVERY BED

Here's the most versatile bed ever made for hospital use. Designed for recovery or intensive care areas, it serves a variety of other purposes as well.

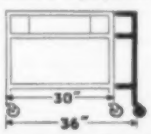


Looks like a bed — not a piece of surgical apparatus. This tends to make the patient feel more "at home," more assured of recovery status.

27 x 12 x 1" storage tray is standard equipment. Adds to convenience particularly when moving patient from area to area. Attaches at either end of bed.



Hard's Slida-Side, the modern, space-saving, time-saving safety side is standard equipment.



30" width Recovery Bed standard, No. 1483RG and 1484RG. *Available also in 36" width, known as Hard Converta-Bed. No. 1485PG.*

Foot guard, Bucks Extension, Bierhoff Crutches, available as accessories.

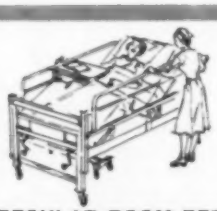
REALLY 6 BEDS IN ONE

EYE BED

Head piece removed. Bed permits access for eye work or other activities at the head area.

ORTHOPEDIC BED

When both head and foot pieces are removed, the bed will accommodate standard round tube overhead fracture frame for orthopedic use.



REGULAR ROOM BED

The bed is a handsome furniture piece that looks well in the standard modern hospital room, and works in conjunction with other hospital room furniture and equipment. HARD's 12-year guaranteed PG 16-position spring provides Trendelenberg, Fowler and Hyper-Extension as well as all standard treatment positions.

RECOVERY BED

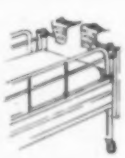
Bed is equipped with fittings for 1506PG Slida-Side Safety Sides which offer greatest possible protection, especially when bed is used for recovery. Large ball bearing casters make this an easy bed to move from Recovery or Intensive Care Areas to patient's room.

FRACTURE BED

With head or foot piece removed, end of bed is flush with mattress surface, allowing a direct pull at mattress level for traction with Bucks Extension.

DELIVERY BED

Bierhoff knee crutches quickly and easily installed at foot end for emergency deliveries.



No. 1484RG 30" WIDTH – No. 1485PG 36" WIDTH

HARD MANUFACTURING COMPANY

BUFFALO 7, NEW YORK – FOUNDED IN 1876

ROVING REPORTER

Beach Club Shells Out Funds

Members of a beach club at Naples, Fla., have come up with an unusual idea to benefit the Naples Community Hospital, Administrator John M. Shaw reports.

The men are enthusiastic about the hobby of collecting shells, which a number of their wives have taken up. In tribute to this time consuming occupation, which leaves the men free to play golf, they have erected a huge shell outside the "19th hole" of the beach club, as a way to honor the unknown patron of shelling.

The shell, standing on a concrete base, bears a sign asking that donations be dropped into the water it contains. Proceeds go to the hospital.

In addition to helping the hospital, writes Tom Hayer of the *Collier County News*, the coin-droppers can make a wish for a hole-in-one, a par 72, or any other ambition.

An anonymous friend of the hospital has the job of emptying the coins from the shell each night and refilling it with fresh water. At last report, the coins were splashing merrily.

Machine Records Blood Loss

An electronic machine that enables doctors to know when a patient needs a blood transfusion during surgery has been devised by a Veterans Administration surgeon, the V.A. announced recently.

Called a blood-loss monitor, the new instrument automatically and continuously measures the amount of blood lost by a patient during an operation.

It was originated by Dr. Harry H. LeVeen, chief of surgery at the V.A. hospital in Brooklyn, N.Y. He said measurements of blood loss made by the monitor are accurate to within one-half of 1 per cent.

The machine is in use at the Brooklyn hospital for all heart surgery and for most operations for cancer, burns and other conditions in which heavy blood loss is likely to occur, he said. The monitor is about 2 feet square.

Sponges and drapes used in surgery are dropped into a wire basket inside the machine and agitated in a measured amount of water to remove the blood. Other blood lost at the site of surgery is sucked into the same water through a tube.

As blood is added to and mixed with the water, the electrical conductivity of the solution changes. The machine measures this conductivity and translates the changes into cubic centimeter measurements of bood loss. The cumulative blood loss is measured on a dial at the front of the monitor.

Postcards Play a Part

Picture postcards are a part of the public relations program of Louise Marshall General Hospital, Mount Forest, Ont. As reported in a recent issue of *Hospital Highlights*, the bulletin of the Ontario Hospital Association, the postcards are sent to future patients, together with preadmission application forms. They also are distributed among patients for their use in sending messages to relatives and friends.

Help Settle the Dust

The staff members at Children's Hospital, Columbus, Ohio, looked forward to the day this spring when construction started on a five-story addition.

But, as with all building projects, they expect some temporary inconvenience, especially since the new structure is going up on the present front lawn.

However, the first issue of *Pedia-*

script, the hospital's new publication for personnel, associates and alumni, added a light touch to the planning for the expansion.

Under the title, "Help Settle the Dust," Administrator R. M. Porter wrote:

"Did you ever remodel your house . . . with the kids under foot . . . people getting hungry three times a day . . . life going on in spite of plaster smears, doors left open, big crates set down in the middle of everything?

"That's the way it's going to be around here when we get going on our new building. It will be worth all the trouble to get what you see on the front page of *Pediascript* (an artist's rendering of the addition), but we will all have to draw heavily on our reserves of patience, good humor —and good temper.

"Among things we're to put up with:

"The ground and first floor windows facing Livingston Park will be sealed off almost as soon as work starts. Stuffy. No view.

"The front lobby will be planted in the present personnel office area inside the west court, and the west court will be closed over.

"We won't be able to spend a red cent for additions to present equipment or facilities because these temporary expedients must be paid for out of operating funds—not new money for the building addition. So, watch your breakage and, in the good old New England fashion . . . 'make do.'

"A further caution—help parents and visitors all you can. Things will be confused enough without them getting poured in the concrete.

"Watch your own step, of course. We'd hate to discover 30 years from now that we had sealed a faithful employe in the wall. You'd be hungry by then."

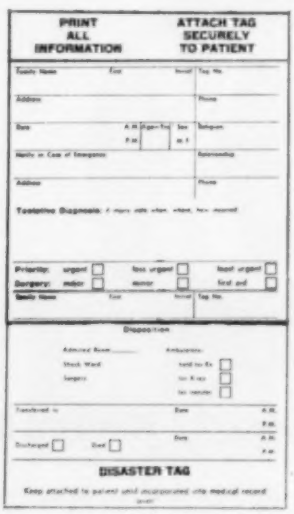
Patient Identification Tag Aids in Indiana Disaster

A Wisconsin railroad disaster in May 1956 has produced results that helped an Indiana hospital cope with 400 cases of food poisoning in April 1958.

Following a railroad accident in Waukesha, Wis., two years ago, Administrator Robert M. Jones of Waukesha Memorial Hospital developed specifications for a patient identification tag that could be used in disasters. He felt the tag should be in duplicate or triplicate, with carbons, so that copies could be forwarded to a central office that could give patients' names to relatives and the representatives of the press.

An editorial in the June 1956 issue of The Modern Hospital passed along Mr. Jones' suggestion, and added that some manufacturer could perform a valuable service for hospitals and the public by developing such a disaster tag.

A tag that met the requirements was produced last fall by Physicians' Record Company, Chicago. These tags were used at Crawfordsville, Ind., in April, when Culver Hospital was besieged with teen-aged girls ill with food poisoning. The tags proved highly satisfactory, according to Administrator Ralph M. Haas. (The story appears on page 62.)

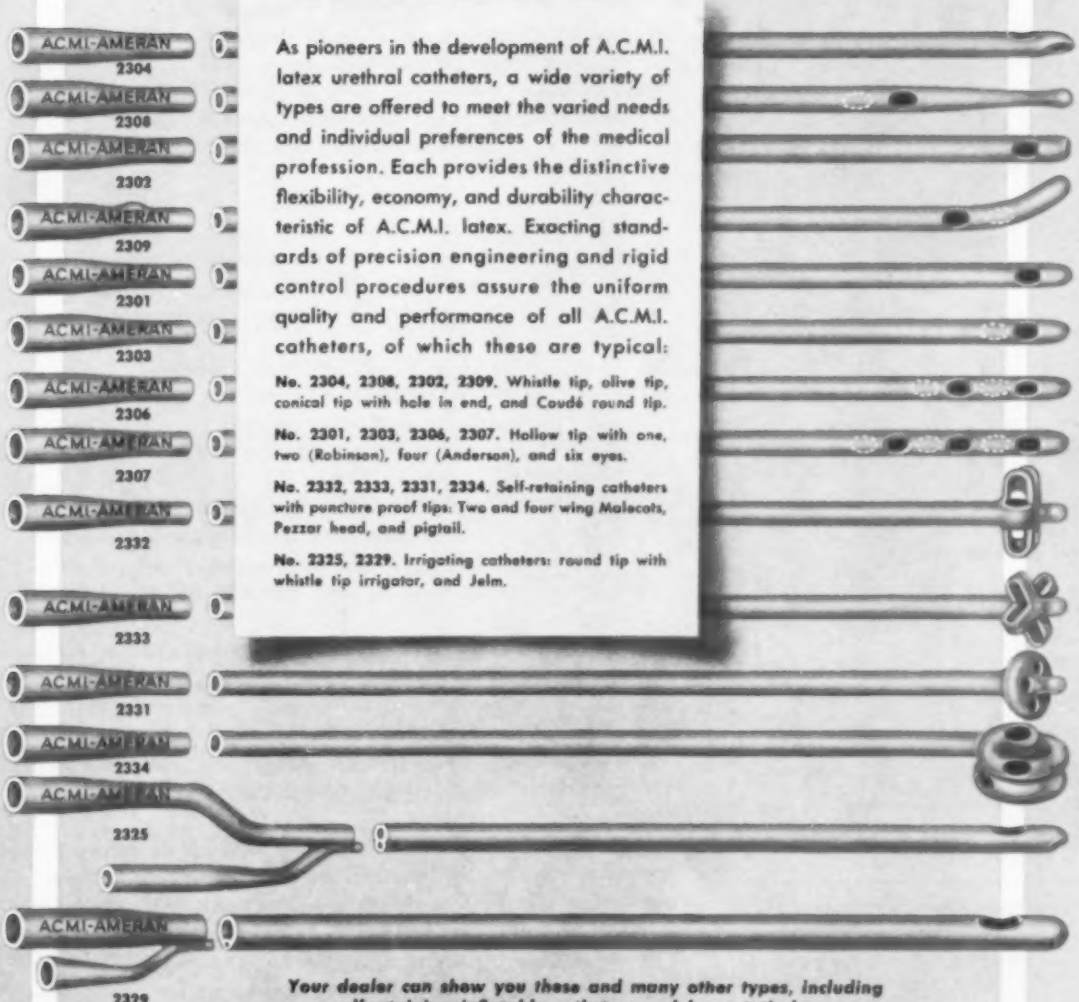


Front of disaster tag is at left; reverse side is at right. Top half of front of tag has two carbons to make copies for admitting department and information center. Tag is then attached to the patient.

For unsurpassed quality . . .

LATEX URETHRAL CATHETERS

by A.C.M.I.—to meet varied requirements



As pioneers in the development of A.C.M.I. latex urethral catheters, a wide variety of types are offered to meet the varied needs and individual preferences of the medical profession. Each provides the distinctive flexibility, economy, and durability characteristic of A.C.M.I. latex. Exacting standards of precision engineering and rigid control procedures assure the uniform quality and performance of all A.C.M.I. catheters, of which these are typical:

No. 2304, 2308, 2302, 2309. Whistle tip, olive tip, conical tip with hole in end, and Coudé round tip.

No. 2301, 2303, 2306, 2307. Hollow tip with one, two (Robinson), four (Anderson), and six eyes.

No. 2332, 2333, 2331, 2334. Self-retaining catheters with puncture proof tips: Two and four wing Malecots, Pezzer head, and pigtail.

No. 2325, 2329. Irrigating catheters: round tip with whistle tip irrigator, and Jelm.

Your dealer can show you these and many other types, including self-retaining inflatable catheters and hemostatic bags.

FREDERICK J. WALLACE, *President*

American Cystoscope Makers, Inc.

8 PELHAM PARKWAY — PELHAM MANOR, N. Y.

Everyone Talks About Public Relations But Not Many Do Anything About It

By Gordon Davis

Gordon Davis

I KNOW a man who has one of the most dazzling arrays of hand and power tools that it has ever been my envious pleasure to gaze upon. He hasn't done much with his tools, but they are wonderful to talk about and to exhibit to his friends.

The case bears a strong resemblance to some hospital public relations. Good public relations has been one of the finest conversation pieces among hospital folk for years. Everybody wants it, and a few have bought the tools and are brandishing them purposefully.

But not too much gets built in this alluring area.

My friend with the tool trove enjoys a relatively uncomplicated situation. If he ever starts to use his tools, they will assist him in turning out something that he can see and feel with his hands. In hospital public relations, however, the end product unfortunately is invisible and nebulous—a public attitude that is subject to only loose measurement.

And this, to me, is one of the chief reasons nearly everybody talks about public relations and virtually nobody does anything about it.

Is it right for a hospital to spend the patient's money on anything so vague? If it is right, how much should be spent? How should a public relations program be initiated? How is it possible to be sure of good results?

Wrestling with questions such as these has produced a welter of public relations inaction in hospital after hospital across our land.

And yet it is right to demand the answers, to refuse to be unduly beguiled by the tools and the glamorous gadgets of public relations. The purposes and capacities of a good tool should be understood before it is picked up. Otherwise the user is like the cowboy using a butcher knife to pick his teeth. He gets poor results at disproportionate risk.

The chief purpose of this column has been to discuss the nature and functions and principles of hospital public relations; its chief hope is that this assists in better application of the tools. In addition, there are scores and hundreds of references which you can probe for new wrinkles in turning out a publicity release, a patient booklet, an annual report.

The addition of organized public relations to the basic functions of every qualified hospital is as inevitable as once was the installation of x-ray and laboratory services. It is no longer a question of whether; it is only a question of when.

Now..."COLD" STERILIZATION WITH THE AMERICAN Cry-O-THERM

Climaxing more than eight years of intensive research and development by American Sterilizer, the *Cry*-O-Therm establishes wholly new standards for cold (gaseous) sterilization of instruments and wrapped or pre-packaged surgical and laboratory supplies. Simple to install, easy to operate, fast, safe and fully automatic, the *Cry*-O-Therm provides the first completely practical technique for hospital sterilization of heat- or moisture-sensitive items.

An Exclusive

new gaseous sterilizing agent known as Cry-OXCIDE *has been developed by Amsco. In convenient, disposable, aerosol containers, Cry*-OXCIDE *combines ethylene oxide and inert gases in a low-pressure, non-flammable, non-explosive mixture.*

Tested and approved by U. S. Bureau of Mines for hazardous locations.

Square 16" x 16" x 30" chamber has ample capacity for largest endoscopic instrument. Fully automatic with full-load cycles as fast as two hours.

Write for bulletin SC-310.

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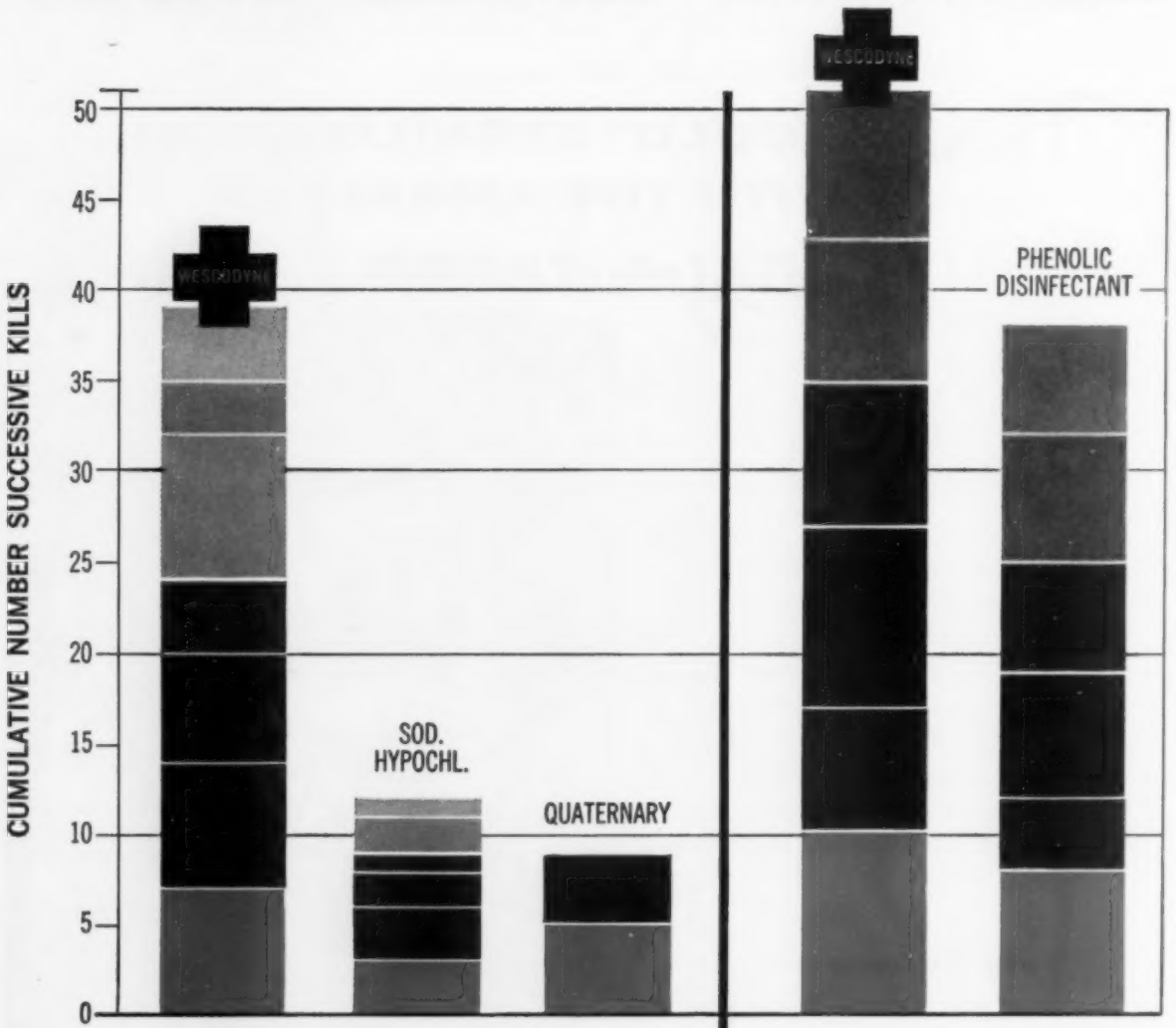
TESTS SHOW GREATER



Capacity Test for Germicidal Action. (A. Cantor and H. Shelanski as described in Soap and Sanitary Chemicals, February 1951.) **Explanation:** This method essentially consists of adding to the use-dilution of the disinfectant or sanitizer, successive doses of a 50/50 mixture of milk plus broth culture of test organisms. These doses are added at ten minute intervals. Thirty seconds after each addition, a transfer is made into broth containing a suitable inactivator. This method makes it possible to determine the capacity of a germicide to kill before the micro-organisms and organic contamination have exhausted its germicidal action. **Organisms:** Salmonella typhosa, ATCC #6539; Micrococcus pyogenes. var. aureus, ATCC #6538; Salmonella pullorum, ATCC #9093; Pseudomonas aeruginosa, ATCC #8689; Trichophyton interdigitale Emmons 640, ATCC #9533; Penicillium luteum, ATCC #9644; Saccharomyces cerevisiae, ATCC #10274. **Dilutions:** WESCODYNE: 1:320 (50 ppm available iodine); Sodium hypochlorite: (100 ppm available chlorine); Quaternary: (50%) 1:5,000 (200 ppm active ingredient). **Temperature:** 15°C. **Media:** Fluid thioglycolate medium, USP XIII was used for testing WESCODYNE and sodium hypochlorite "Letheen" broth was used for testing alkyl dimethyl benzyl ammonium chloride.* All tests were re-subcultured in the same medium. **Results:** See above chart. **Conclusion:** The cumulative number of successful kills shows WESCODYNE to be over three times more effective than the nearest material tested.

*Neopeptone dextrose broth was used for testing the alkyl dimethyl benzyl ammonium chloride against the three fungi.

Wescodyne vs. Leading Phenolic Disinfectant. (A. Cantor and H. Shelanski Capacity Test as described in Soap and Sanitary Chemicals, February 1951.) The method used in this test is the same as that used in the Capacity Test for Germicidal Action described at left. **Dilutions:** WESCODYNE: 1:213 (75 ppm available iodine); phenolic disinfectant: 1:100 **Temperature:** 15°C. **Media:** Fluid thioglycolate medium, U.S.P. XIII was used for testing WESCODYNE and FDA nutrient broth was used for testing the phenolic disinfectant. All tests were re-subcultured in the same medium to eliminate bacteriostasis. **Results:** see above chart. **Conclusion:** This test shows that the bactericidal effectiveness (in the presence of organic contamination) of WESCODYNE at a dilution of 1:213 (75 ppm available iodine) is greater than that of a leading phenolic disinfectant at a dilution of 1:100.

PATHOGEN COLOR KEY:

- Salmonella typhosa (typhoid organism)
- M. pyogenes v. aureus (staphylococcus organism)
- Salmonella pullorum (poultry disease organism)
- Pseudomonas aeruginosa (wound contaminent organism)
- Trichophyton interdigitale (athlete's foot type of fungus organism)
- Penicillium luteum (mold organism)
- Saccharomyces cerevisiae (yeast organism)
- Strep. pyogenes hemolyticus (streptococcus organism)
- Escherichia coli (enteric organism)
- Shigella sonnei (dysentery organism)
- Salmonella schottmuelleri (food contaminent causing dysentery)

GERMICIDAL CAPACITY

WESCODYNE's advantages are extraordinary. Its greater germicidal capacity is shown at left. Two other features are equally outstanding:

❶ Nonselective biocidal activity destroys T.B., Polio, other viruses, bacteria, spores, fungi. This wide-spectrum effectiveness is greater than that offered by solutions containing chlorine, cresylics, phenolics or quaternaries.

❷ Strong detergent action combines cleaning and disinfecting into a simplified one-step procedure.

WESCODYNE is the single hospital germicide suitable for all disinfecting and sterilization procedures, including those for the prevention of cross infection. It is nonstaining, nonirritating, nontoxic. Leaves no odor. Saves time and labor because it cleans as it disinfects.

WESCODYNE costs less than 2¢ a gallon at the general-purpose use dilution of 75 ppm available iodine. Sound worthwhile? Send the coupon for full information and recommended O.R., housekeeping and nursing procedures.

Specialties and Programs for Protective Sanitation and Preventive Maintenance

WEST CHEMICAL PRODUCTS INC.

WEST DISINFECTING DIVISION

WEST CHEMICAL PRODUCTS, INC., 42-16 West Street, Long Island City 1, N. Y.
Branches in principal cities • In Canada: 5621-23 Casgrain Ave., Montreal

☐ Please send recommended procedures and full information on Wescodyne.
☐ Please have a West representative telephone for an appointment.

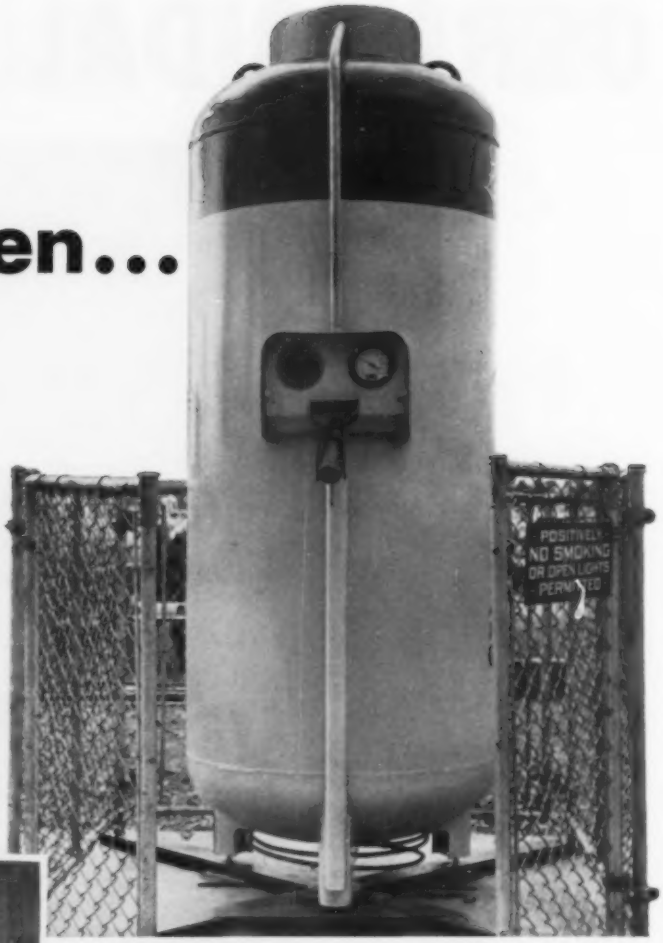
Name _____

Position _____

Mail this coupon with your letterhead to Dept. 25

For Liquid Oxygen... *It's LINDE!*

More hospitals can now enjoy the advantages of liquid oxygen storage. LINDE'S *expanded service* provides three distinct supply systems that meet the needs of large, medium and smaller oxygen consumers.



ATX LIQUID STORAGE AND CONVERTER
A *new* LINDE system with 25,000 cu. ft. capacity—brings advantages of a liquid supply to hospitals that could not before utilize liquid oxygen. Constantly supplied and maintained by LINDE or your local LINDE distributor.

VCC-90 LIQUID STORAGE AND CONVERTER
Provides ample liquid oxygen for larger users. Unit contains equivalent of 90,000 cu. ft. of gaseous oxygen.

LC-3 LIQUID CYLINDERS
Convenient, easy-to-handle cylinders of liquid oxygen, each holding the equivalent of 3000 cu. ft. of gas. Can be manifolded to provide a continuous supply to a piping system or can be used at the bedside.

To learn more about the convenience, efficiency, and economy of these liquid oxygen systems, just call your nearby LINDE distributor or LINDE office. Or write to Dept. F-6, LINDE COMPANY, Division of Union Carbide Corporation, 30 East 42nd Street, New York 17, N. Y. Offices in other principal cities. *In Canada:* Linde Company, Division of Union Carbide Canada Limited.

Linde TRADE MARK

UNION CARBIDE

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A REMINDER FROM MERCK SHARP & DOHME:

NOW IS THE BEST TIME TO ORDER

ASIAN FLU VACCINE

Recent outbreaks of influenza indicate the possibility of a recurrence of Asian Influenza in the United States in late 1958 or early 1959. Ordering your requirements <u>now</u> will assure you of sufficient vaccine when it is needed.

TEAR OUT

Postage Will be Paid by Addressee

No Postage Stamp Necessary If Mailed in the United States

BUSINESS REPLY CARD
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MERCK SHARP & DOHME
Vaccine Department
640 North Broad Street
Philadelphia 1, Penna.

Remember how difficult it was to obtain Asian Influenza vaccine during the past flu season?

To make certain that you have an adequate supply when the need again arises, you should order vaccine *now*. Order for immediate delivery or, if you prefer, at whatever future date you specify.

Vaccination against Asian Influenza is inexpensive—and is the only effective way of minimizing the risk of contracting this highly contagious disease which causes so much debilitation and absenteeism.

By anticipating your needs and ordering now, you can be certain that you will have enough vaccine for your personnel and patients.

Influenza Virus Vaccine Monovalent

400 C.C.A. units Asian Strain per cc.
Recommended adult dose: 1 cc. intramuscularly in early autumn.

Influenza Virus Vaccine Polyvalent

200 C.C.A. units Asian Strain
100 C.C.A. units PR8
100 C.C.A. units PR301
100 C.C.A. units Great Lakes
500 C.C.A. units Total

Recommended adult dose: 1 cc. intramuscularly in August or September, followed by 1 cc. intramuscularly three months later.

MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

MERCK SHARP & DOHME
VACCINE DEPARTMENT
640 NORTH BROAD STREET
PHILADELPHIA 1, PENNA.

Please ship the following to arrive on _____
(specify delivery date)

_____ *10 cc. vials Influenza Virus Vaccine Monovalent*

_____ *10 cc. vials Influenza Virus Vaccine Polyvalent*

Ship to: _____ *Bill to:* _____

_____ _____
(Street address) *(Street address)*

_____ _____
(City and State) *(City and State)*

Purchase order number _____

TEAR OUT

Did the outdoors smell fresher today?

When you stepped outdoors did the air smell much fresher? If it did, then you can imagine the contrast a visitor experiences when he enters your institution. His reaction is based on the change of smells in the air—from pleasant outdoors to a "hospital" odor.

Reducing this contrast so that patients and visitors are not influenced by unpleasant odors is Airkem's contribution to the hospital field. Airkem cleaning agents or air treatment products neutralize smells through odor counteraction and add a freshened effect to indoor air. Because of this unique action, Airkem products are effective in problem wards and other difficult areas, without adding a strong chemical smell to the air.

Airkem "A-3" is an example of how a cleaning and sanitizing product can also help reduce the odor level. The surface-active ingredients in "A-3" take the effort out of cleaning, effectively inhibit bacteria growth and kill odors on surfaces and in the air. Airkem "A-3" combines a synthetic, non-ionic detergent, a quaternary sanitizer, an organic chelating agent and Airkem exclusive odor counteractants.

Selected Airkem formulations are available for controlling general occupancy odors, high-level odor concentrations and live animal smells. Airkem is also packaged in convenient aerosols for emergency use. Where continuous odor protection is required, "Osmefans" or electrical dispensers designed to treat specific areas are used to circulate Airkem odor counteractants.

airkem

Specialists in Odor Control

Your hospital may have odor problems that have thus far defied remedy. Whether in wards, post-operative areas or in special cases such as incontinence and vomitus, Airkem products will be of particular help to you. Write for free information.

AIRKEM, INC., 241 East 44th Street, New York 17, New York

- ☐ Please send me information on the Airkem system of products for hospital use
- ☐ Please have an Airkem representative call

Name_____

Title_____

Institution_____

Address_____

City_____ Zone_____ State_____

MH-6S

Libbey Heat-Treated DATED Glassware

"is a real money-saver in our restaurants"

Hayes-Bickford Lunch System Inc.
32 GARRISON STREET
Boston Massachusetts
TELEPHONE COMMONWEALTH 6-0111

Libbey Glass
Division of Owens-Illinois
Toledo 1, Ohio

Gentlemen:

In our 17 Hayes-Bickford restaurants we have used Libbey Heat-Treated DATED Glassware for many years, with complete satisfaction.

Yet we were amazed when we made our own survey to find the actual servings each tumbler produced. Using the code symbol on every glass, we were able to prove that tumblers averaged 3,700 servings--for the fantastically low cost of 1 4/5 cents per 1,000 servings.

Your Heat-Treated glassware stands up perfectly under rugged service conditions, and is a real money-saver in our restaurants.

Sincerely,

Charles F. Heywood

Charles F. Heywood
Purchasing Agent

Mr. Charles F. Heywood
Purchasing Agent
Hayes-Bickford Lunch System, Inc.
Boston, Massachusetts

Hayes-Bickford restaurants are familiar throughout Boston for fine meals moderately priced.

Mr. Charles F. Heywood, Purchasing Agent for Hayes-Bickford, operating 17 restaurants in Boston, Mass., has proved the operating economy provided by Libbey Heat-Treated DATED Glassware.

It's a simple matter to make your own survey. For eight years a code symbol indelibly marked on the bottom of every Heat-Treated glass has made it possible to trace the use of each glass. A check of this glassware will quickly show its amazing durability and resulting economy in restaurant operation.

Economical operation is further assured by the famous Libbey guarantee: "A new glass if the rim of a Libbey 'Safedge' glass ever chips."

Your Libbey Supply Dealer has full details on how Heat-Treated DATED Glassware can minimize your glassware costs.

See him or write to Libbey Glass, Division of Owens-Illinois, Toledo 1, Ohio.

This symbol appears on the bottom of every Heat-Treated DATED glass. Left number indicates year of manufacture, right shows quarter. Add up the number of servings to prove the unbelievable economy of this glassware.

LIBBEY HEAT-TREATED GLASSWARE
AN (O) PRODUCT

OWENS-ILLINOIS
GENERAL OFFICES · TOLEDO 1, OHIO

FREE OFFER!

to prove that Instant Maxwell House is better for your operation than ground coffee!

The experience of successful users of Instant Maxwell House Hotel and Restaurant Coffee has proved that it is better than ground coffee for food service operations. Instant Maxwell House H&R Coffee was developed especially for the food service industry. We want you to try a free supply because we know you'll continue to serve it. And here are the reasons why:

- Instant Maxwell House has *uniformity of flavor*. Day in, day out, you can serve the same delicious cup of coffee!
- Instant Maxwell House offers *substantial economy*. Gives 10% greater yield. No coffee is wasted in grounds.
- Instant Maxwell House *can be made by anyone*—with your present equipment or in a special instant coffee machine, if you desire.
- Instant Maxwell House *saves labor*, eliminates 3 out of every 4 man-hours now spent in preparing ground coffee.
- And—Instant Maxwell House has proven consumer acceptance—it is *America's largest-selling coffee!*
- It is conveniently packaged in urn-size, glassmaker-size, and individual envelopes.

Yes, Instant Maxwell House is better for your operation than ground coffee—and you can prove it for yourself! Mail the coupon below for a FREE one-day trial supply of coffee and demonstration. There's no obligation to buy.

A Product of General Foods

GF INSTITUTIONAL PRODUCTS DIVISION

GENERAL FOODS CORPORATION
INSTITUTIONAL PRODUCTS DIVISION
WHITE PLAINS, N. Y.

Post CEREALS

INSTANT SANKA COFFEE

Log Cabin Syrup

good seasons
SOUP BASES AND SEASONINGS

MAXWELL HOUSE COFFEE

JELL-O DESSERTS

FREE OFFER

General Foods Corporation
Institutional Products Division
White Plains, New York

We're interested in a free one-day trial supply of Instant Maxwell House H&R Coffee and a demonstration. I understand we are under no obligation to buy.

Name..... Title.....

Organization.....

Address.....

City..... State.....

Equipment used (check one) ☐ Urn ☐ Glassmaker

Number Cups Served Per Day

OFFER EXPIRES MARCH 31, 1959 Dept. V

Even light eaters are tempted with a Heinz Pickle

SAMPLE HEINZ PICKLES—GET $1.00 PICKLE FORK FREE!

• Get one of these beautifully designed Wm. Rogers *silver-plated* pickle forks ($1.00 value) FREE! Just fill out and mail the coupon below. Your free pickle sample and free fork will be sent to you promptly.

H. J. Heinz Co., P. O. Box 57, Pittsburgh 30, Pa.

I would like a free pickle sample as checked below (Check one):

☐ Hamburger Slices	☐ Genuine Dills	☐ Sweet Sticks
☐ Cross-Cut Kosher	☐ Fresh Cucumber Relish	☐ Sweet Pickles
☐ Whole Kosher	☐ Sweet Gherkins	☐ Sweet Relish
☐ Fresh Cucumber	☐ Sweet Midget Gherkins	☐ Hot Dog Relish
☐ Cross-Cut Sweet	☐ Sweet Mixed	☐ Hamburger Relish

Name_____

Name of Business_____

Address_____

City_____ Zone_____ State_____

Offer good in Continental U.S.A. and Hawaii. Void in all states where prohibited by law. Use for any other purpose than stipulated constitutes fraud. Offer limit one to a customer. Expires August 31, 1958. MH-68

There's a Heinz

RELISH—Sweet, Hot Dog, Hamburger and Fresh Cucumber

SPECIALTY—Sweet Mixed and Sweet Sticks

Heinz

by sandwiches garnish

Dress-up ordinary sandwiches with Heinz Pickles to wake up the laziest appetites. This low-cost garnish makes *any* sandwich look more attractive . . . taste even better! You'll like the way Heinz Pickles give a tempting lift to other foods, too. For real flavor magic, try adding chopped pickles to ordinary salads. Their spicy goodness makes plain dishes really great. Heinz Pickles, costing just a penny or so per serving, complement the finest prepared foods.

● **So by all means** serve Heinz pickles. They're always tempting, crisp and flavorful. That's because they're made with the finest ingredients . . . Heinz own tender-skinned, select cucumbers, sparkling Heinz White Vinegar and rare spices. Just try them yourself and discover why more people eat *Heinz* Pickles . . . they're delicious!

● **Ask your salesman** about the Heinz Pickles best for your use. Begin by ordering several of Heinz 15 Pickle varieties.

Pickle for Every Purpose

ECONOMICAL CROSS CUT—Hamburger Slices, Kosher Dill, Sweet and Fresh Cucumber

UTILITY, ALL PURPOSE WHOLE—Kosher Dill, Sweet Gherkins, Genuine Dill, Sweet Pickles and Sweet Midget Gherkins

Pickles 57

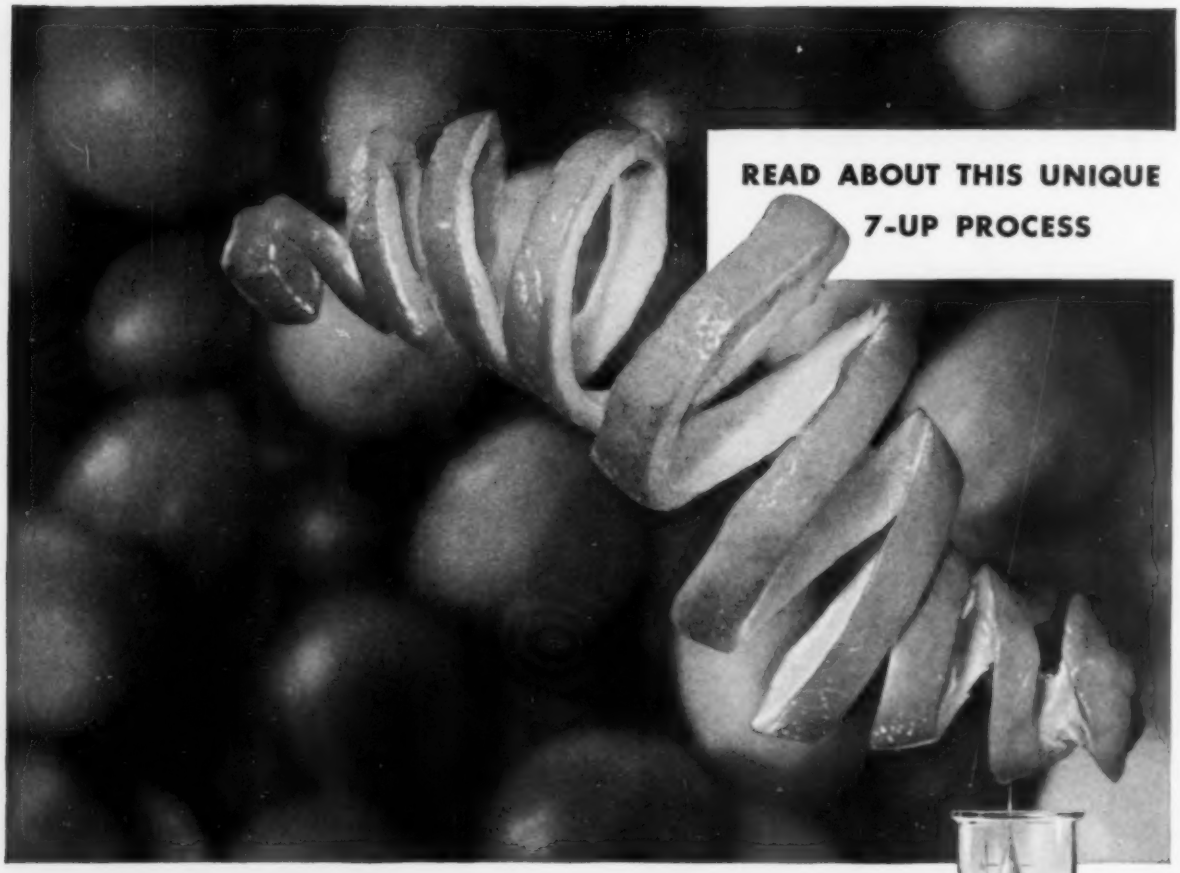
NOBODY MAKES PICKLES LIKE HEINZ

QUICK TRICK TO TASTIER TARTAR SAUCE

● Combine equal parts Heinz Salad Dressing and Heinz Sweet Relish. Thrifty, easy . . . more delic'ous than ready-made sauces.

New! Heinz Salad Dressing makes your salads tastier

● **Tempt sagging appetites** with dishes made with new Heinz Salad Dressing. Its improved flavor and consistency really perks up ordinary salads and sandwiches. And Heinz new process keeps this tastier Salad Dressing uniform in quality from the top of the jar to the bottom. It's your assurance against waste. Order new Heinz Salad Dressing next time your salesman calls. Also ask him about full-flavored Heinz French Dressing. It's a silken-smooth, homogenized blend of vegetable oil, Heinz White Vinegar, and tomato purée.



Only the quintessence... is good enough for 7-UP

We had to go some to outwit Nature and perfect 7-Up.

Nature hid 7-Up's secret well—inside the *peel* of fresh lemons and limes. There, in minute quantities, a fragrant oil resides which penetrates the "meat" of citrus fruits to create their clean, tangy flavor.

Extracting this natural fruit essence takes special equipment, time, care and money. From this, 7-Up refines and selects only a tiny fraction—the very best—for use in the extract from which 7-Up itself is made.

To produce 1 ounce of concentrated 7-Up flavor literally takes thousands of fresh lemons and limes. That's why 7-Up is Nature's own gift . . . a pure, wholesome, natural flavor.

For a fresh, clean taste . . . 7-Up.

TO EXTRACT ONLY
1 OUNCE
OF 7-UP FLAVOR ESSENCE
WE SQUEEZE THE PEEL OF
THOUSANDS
OF FRESH LEMONS
AND LIMES

7up

Nothing does it like Seven-Up!

"Our 17 years' experience with has been a dependable and

CHARITY HOSPITAL
NEW ORLEANS, LOUISIANA

Charity Hospital of Louisiana is the largest general hospital in the South and one of the three largest in the U. S. It is also the heart of the medical center for Louisiana State University and Tulane Medical School.

In 1957, there were 1,155,604 patients seen at Charity including 13,102 births. This birth rate and the outpatient traffic were the largest of any general hospital in the U. S.

Charity Hospital also has a large research center. 225,000 medical charts are pulled each year for research and study.

"We are primarily interested in having our 44 OTIS Elevators retain their original safety, dependability and efficiency," says Dr. LEO J. KERNE, Director, CHARITY HOSPITAL of Louisiana in New Orleans. "And being a State owned institution, we must receive an assurance of this at an absolute minimum cost to the taxpayers.

"CHARITY HOSPITAL is a modern 20-story hospital containing 2,984 beds, classrooms for students and living quarters for professional hospital personnel. Our elevators carry approximately 33,000 persons per day; therefore it is understandable when we say that our elevators are the heart of our operation. It is imperative that they stay in first class operating condition.

"To receive this assurance we naturally rely on the manufacturer of the equipment. OTIS built it, let OTIS maintain it. It only stands to reason that OTIS is in the best position to provide the technical data, special tools, skilled personnel trained on our type of equipment and sufficient inventory to guarantee us the performance we demand out of our OTIS Elevators.

"Our 17 years' experience with OTIS Maintenance has proved to be a profitable relationship. We would readily recommend Manufacturer's Maintenance."

"world's word for elevator quality"

Otis elevator

"ENGINEERED SERVICE BY THE MAKER"

OTIS ELEVATOR COMPANY • 260 ELEVENTH AVENUE • NEW YORK 1, N.Y.


Stop
this
With
this!

Honeywell Round,
world's most popular thermostat.

Nurses aren't trained to control room temperatures

Honeywell bedside thermostats are.

Honeywell bedside thermostats
free busy nurses from chambermaid chores.

Today, when 64% of hospital expenditures are for payroll, one important answer to cost reduction lies in increasing self service by the patient. And Honeywell Bedside Temperature Control allows patients to adjust room temperatures to suit themselves, frees nurses from opening and closing windows, filling hot water bottles, carrying blankets and adjusting convectors and cooling equipment.

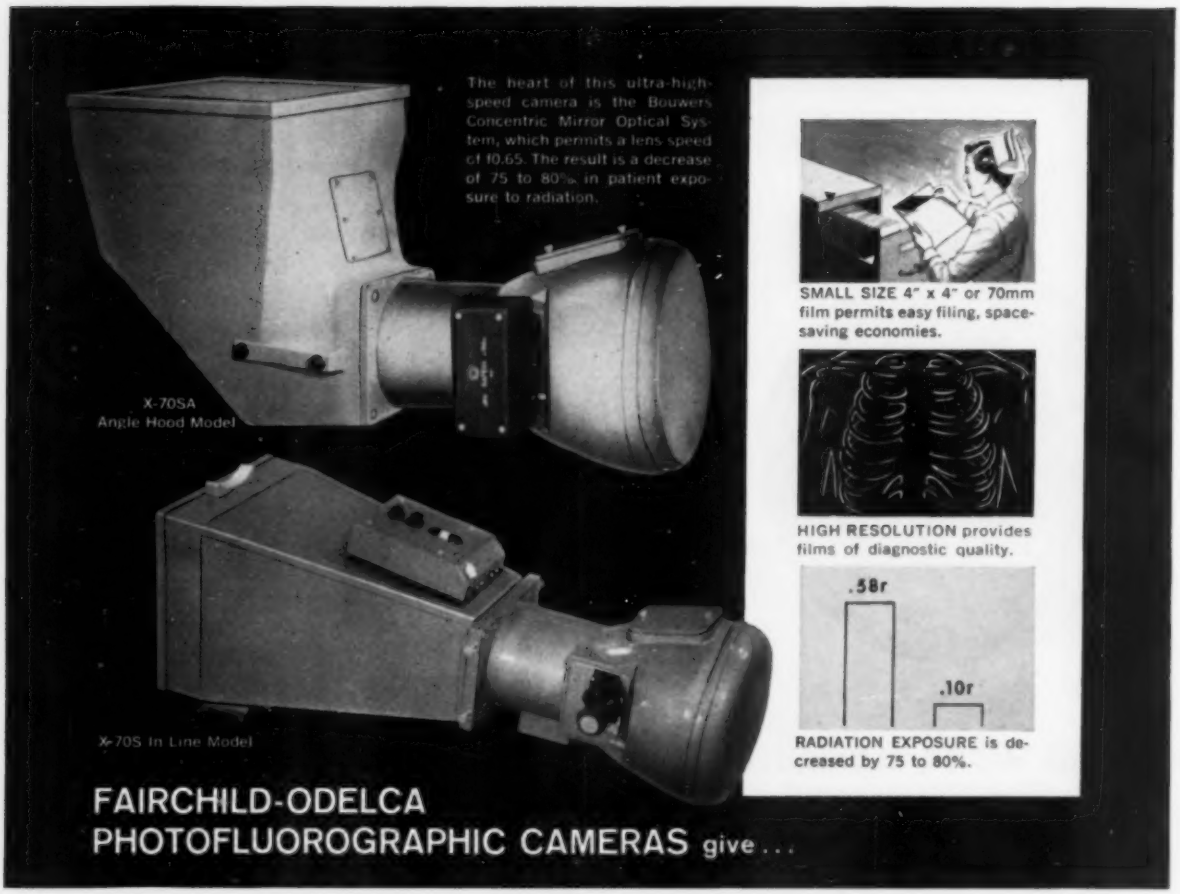
In addition, Honeywell Bedside Temperature Control helps speed patients' recovery because it provides a psychological atmosphere of comfort and, in special cases, doctors can prescribe room temperatures ideal for each patient.

Specify Honeywell Bedside Temperature Control for your new hospital or addition. It can also be added to existing rooms without redecorating or tearing out walls. The outer ring of the famous Honeywell Round Thermostat snaps off for easy decorating, too. And the cost is as low as $87.50 per room.

For more information, call your local Honeywell office or write Honeywell, Dept. MH-6-33, 2727 4th Avenue South, Minneapolis 8, Minnesota.

Honeywell

H First in Controls



Clear, sharp negatives of diagnostic quality with 80% less patient exposure to radiation!

The Fairchild-Odelca Camera provides photofluorographic negatives with 400% better resolution than standard refractive lens cameras. Yet, the camera's high lens speed—more than four times that of refractive lens cameras—reduces patient exposure to X-rays by 70 to 80% . . . stops much voluntary and involuntary motion.

A recently published report by the executive committee of a national association concerned with tuberculosis prevention states: "Whenever the purchase of a new photofluorographic unit is contemplated, the mirror optical system camera is to be preferred over the ordinary lens system." The report further states that this preference is due to reduction in radiation and superiority of results.

Two Camera Sizes Available

The Fairchild Ultra Speed 4 x 4 Camera gives a negative of clear, sharp diagnostic quality, which can be viewed conveniently without magnification and filed with the patient's record. With a Standard Speed Casette and a Standard Safety Monitor, this camera is recommended for hospital admission X-rays. The magazine holds up to 100 sheets of 4" x 4" film, of which one or several may be removed for development at any time after exposure.

The Fairchild 70 mm Camera, equipped with a 100-foot roll film casette, is ideal for routine chest X-rays in hospitals or mass chest surveys in tuberculosis prevention stations. A 40-exposure hand-operated casette is available for routine hospital admissions work; a 40-exposure motor-operated casette permits serial studies at speeds up to six exposures per second.

For complete details on Fairchild-Odelca Photofluorographic Cameras, consult your regular X-ray equipment supplier, or write direct to Faichild Camera and Instrument Corporation, Industrial Camera Division, 5 Aerial Way, Syosset, New York, Dept. 52 P.

FAIRCHILD
X-RAY CAMERAS AND ACCESSORIES

B-P

Here it is »

STERILE *Rib-Back* BLADE

in the
PUNCTURE PROOF
Package

It's Sharp

Naturally, it can be AUTOCLAVED

Don't compromise package safety or blade quality. The B-P STERILE Rib-Back BLADE package provides both—on the outside an easily opened PUNCTURE PROOF envelope that can be autoclaved if desired . . . on the inside a STERILE Rib-Back BLADE of the same superior carbon steel you have always enjoyed.

CARBON steel—the BEST for FINE cutting edges

After all, the first consideration is cutting efficiency no matter how the blade is packaged—and cutting efficiency is exactly what you get with the 'only' B-P Rib-Back Surgical Blade, whether your preference in packaging be . . .

B-P STERILE pack Rib-Back BLADES
B-P RACK-PACK® Rib-Back BLADES
B-P CONVENTIONAL pack Rib-Back BLADES

Ask your dealer

BARD-PARKER COMPANY, INC.
Danbury, Connecticut

BARD-PARKER RIB-BACK BLADES — ALWAYS YOUR BEST BUY IN PERFORMANCE
SUPPLIED IN THE PACKAGE TO MEET YOUR REQUIREMENTS

Improve skull technic with Angligner and radiographic manual. Both for $17.00

Specially designed *Angligner* helps you set correct angle for patient's head, film holder and x-ray tube. Complete with valuable 60-page guide to better skull technic.

Stainless-steel cart offers clean transportation of wet films

$110.00

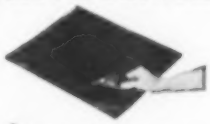
Rubber-tired, stainless-steel film cart will keep your floors dry . . . carries up to 12 wet films at a time. Drip pan catches run-off. Size — 18⅝" wide, 33" long, 33½" high.

Film-hanger drip trays stave off messy floors

Pair $8.00

Clip these trays onto film hangers to catch drippings during wet-film viewing. Small size fits 8 x 10 and 10 x 12 hangers . . . larger size fits 11 x 14 and 14 x 17 hangers.

Flexible film holders . . . outwear "cardboards" by several times



Tape-bound, tough, plasticized-paper exposure holders give you these special advantages: washable . . . pliable . . . won't break at folds or fray at edges. Available with or without lead backs. (See coupon for sizes and prices.)

Safety step stool has countless uses in x-ray department

$8.40

Sure footing is provided by ribbed rubber, no-slip top. Chrome legs with rubber feet . . . non-tipping design . . . top measures 17¼" x 12" . . . height of step, 10⅝".

Now everyone can afford stainless-steel tanks

G-E "5-15-5" processing tanks offer stainless-steel advantages at lowest cost. 5-gal. developer and fixer compartments, 15-gal. wash. Various models. Send coupon for details.

CLIP THIS COUPON . . . Or, to obtain these and hundreds of other quality accessory and supply items, call your nearby General Electric x-ray office. You'll find it listed in the Yellow Pages of your phone book.

SEND TO:
X-RAY DEPT.
GENERAL ELECTRIC CO.
ROOM H-66
MILWAUKEE 1, WIS.

YOUR NAME.....

ADDRESS.....

CITY.....

CHECK ITEMS REQUESTED:

Film: ☐ Ansco ☐ DuPont ☐ Kodak ☐ Screen ☐ No-Screen
(Available in boxes of 25, 75, 100)
☐5"x7" ☐6½"x8½" ☐8"x10" ☐10"x12" ☐11"x14" ☐14x17"

SUPERMIX LIQUIDS	DEVELOPER	REPLENISHER	STAIN-LESS FIXER*	SPEED FIXER
26 oz. makes 1 gal.	$1.42	$1.42	$1.22	$1.27
12 or more, each	1.28	1.28	1.10	1.14
80 oz. makes 3 gal.	3.84			3.52
4 or more, each	3.46			3.17
1 gal. makes 5 gal.	5.07	5.07	4.25	4.61
4 or more, each	4.56	4.56	3.83	4.15

*Comes in 1 and 5 qt. only, to make 1 and 5 gal. of solution.

.....Caliper (regular) $3.50
.....Caliper (deluxe) $8.00
.....Timer $10.95
.....Vent-Axia $55.00
.....Motorless ventilator ..$20.00
.....Speaking grille $11.50
.....Step stool $8.40
.....Wet-film cart $110.00

.....Drip trays:
.....small, pr. $8.00
.....large, pr. $8.00
.....1 of each $8.00

.....Angligner and technic manual $17.00

.....Send me literature on "5-15-5" tanks.

FLEXIBLE FILM HOLDERS

SIZE	5x7	6½x8½	8x10	7x17	10x12	11x14	14x17
Lead back	$2.00	$2.50	$3.00	$3.50	3.50	$3.85	$4.75
No lead back	1.75	2.05	2.75	3.00	2.85		3.85

Shipping charges, sales and use taxes must be added where applicable. Prices subject to change without notice.

Time-Saver. Just 15 minutes to rinse, scour, sterilize, and dry instruments with this all-Monel sterilizer.

How your hospital can handle heavy sterilizing loads

Look at Shreveport's new 325 bed Schumpert Memorial Hospital . . . 22 Wilmot Castle Sterilizers built with Nickel-clad steel and Monel nickel-copper alloy.

In Surgery: 9 sterilizers, including 6 all-Monel* high-speed emergency units.

In Central Supply: a 'round-the-clock processing plant with 2 huge Nickel-clad rectangulars and a Monel cylindrical auxiliary unit.

In Maternity: an automatically controlled autoclave for fast, safe terminal processing of formula.

In Utility Rooms and Laboratory: 9 more all-Monel autoclaves.

In Castle's bulk sterilizer, the inner chamber wall and door is a sheet of Nickel inseparably bonded to a steel shell. For cylindrical autoclaves, Castle uses double walls of Monel alloy.

These nickel containing metals have maximum resistance to corrosive saline solutions, steam, organic debris, cleansers. Surfaces remain smooth and easy to clean. There's no peeling or warping despite repeated temperature extremes. All welded construction virtually eliminates possible leakage.

Any way you look at it, Castle's Monel and Nickel-clad sterilizers are built for a lifetime of service . . . economical service . . . unfailing service.

Need help in planning? Take advantage of Wilmot Castle's Hospital Planning Service. Write: Wilmot Castle, Inc., Rochester, N. Y.

*Registered trademark

THE INTERNATIONAL NICKEL COMPANY, INC.
67 Wall Street INCO New York 5, N. Y.

INCO NICKEL ALLOYS


B-D HYPAK
NOW...TAKE YOUR CHOICE

B-D OFFERS

"DISPOSABLES"

DESIGNED FOR ONE-TIME-USE

B-D HYPAK®

STERILE DISPOSABLE GLASS SYRINGE-NEEDLE COMBINATION

ALL GLASS BARREL—from vial to injection, your medication is safe in clear, Resistance glass—the proven material. **B-D CONTROLLED**—sterile, pyrogen-free, nontoxic. **NEW, SHARP NEEDLE POINT**—greater patient comfort.

B-D YALE®

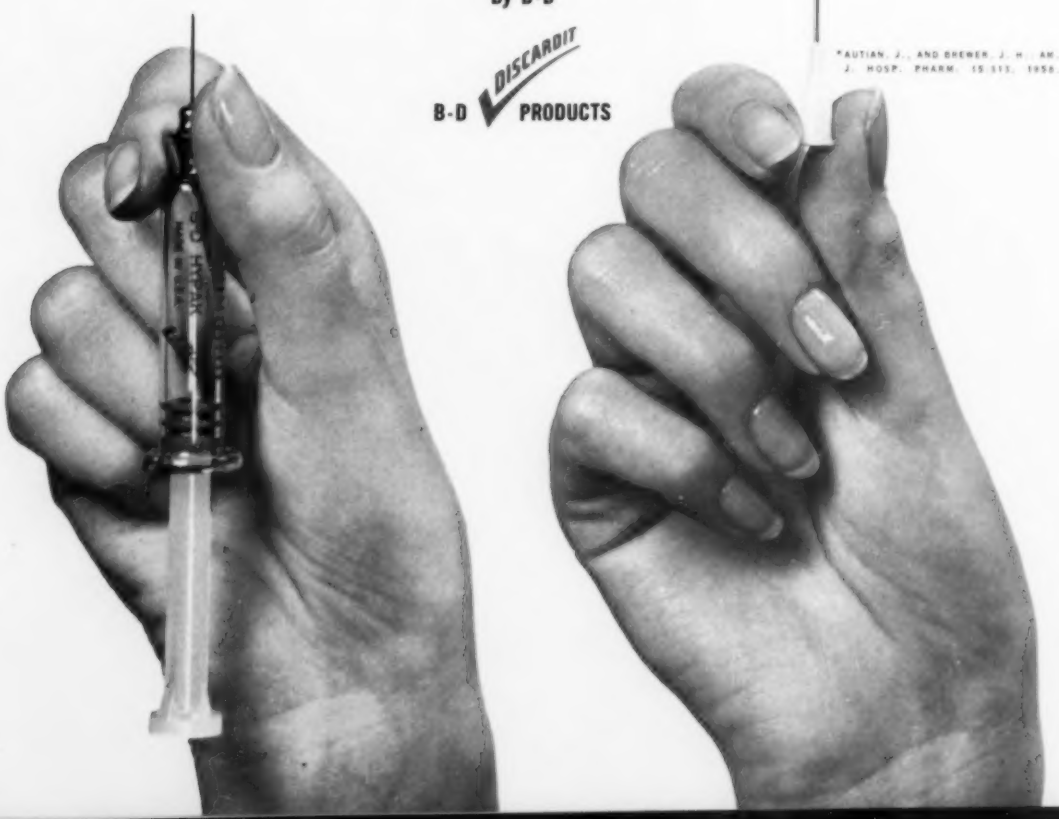
STERILE DISPOSABLE HYPODERMIC NEEDLE

TRULY DISPOSABLE—color-coded, inert plastic hub* will not withstand conventional resterilization. **STERILE, PYROGEN-FREE, NONTOXIC**—B-D Controlled. **SAVES LABOR**—no after-use handling. **NEWLY DESIGNED POINT**—smooth penetration every time. Fits all Luer-Lok® and Luer-Slip syringes.

MANUFACTURED, STERILIZED AND CONTROLLED By B-D

B-D DISCARDIT PRODUCTS

*BAUTIAN, J., AND BREWER, J. H.: AM. J. HOSP. PHARM. 15:511, 1958.



.....OR "REUSABLES"

FOR MAXIMUM IN-USE ECONOMY

B-D MULTIFIT®
INTERCHANGEABLE SYRINGE WITH CLEAR GLASS BARREL

REDUCED BREAKAGE—barrel of clear, Resistance glass unweakened by grinding.
EASILY AND QUICKLY ASSEMBLED —no tedious matching of parts.
LOWER REPLACEMENT COSTS —every plunger fits every barrel.
CONTROLLED FIT —"backflow" eliminated.

B-D YALE
STAINLESS HYPODERMIC NEEDLES

RUST-RESISTANT throughout— STIFF enough to pierce tissues easily —FLEXIBLE enough to bend without breaking —HARD enough to hold a sharp point— TOUGH enough to assure long use.

STANDARD OF THE MEDICAL PROFESSION SINCE 1897

B-D

BECTON, DICKINSON AND COMPANY
RUTHERFORD, NEW JERSEY

DISCARDIT

HYPODERMIC EQUIPMENT

COLOR-CODED for easy identification

YALE
Sterile Disposable Needle

HYPAK Sterile Disposable GLASS
Syringe-Needle Combination

PACKAGED for hospital convenience

YALE STERILE DISPOSABLE NEEDLES—for all B-D Luer-Lok and Luer-Slip Syringes

Catalog No.	Gauge	Color Code
HSYN	25 Gauge x ⅝"	(Blue)
HSYN	22 Gauge x 1"	(Black)
HSYN	22 Gauge x 1½"	(Black)
HSYN	20 Gauge x 1"	(Yellow)
HSYN	20 Gauge x 1½"	(Yellow)

100 needles (20 strips of 5) in sturdy package with handy slide-off sleeve for disposing of used needles. Shelf package: 1000 needles. Case: 5 shelf packages (5000 needles)

HYPAK STERILE DISPOSABLE GLASS SYRINGE-NEEDLE COMBINATION

A702	2 cc. with 25 x ⅝" needle	(Blue)
A702	2 cc. with 22 x 1" needle	(Black)
A702	2 cc. with 22 x 1½" needle	(Black)
A702	2 cc. with 20 x 1½" needle	(Yellow)

Individual unit in sealed polyethylene bag. 20 units per box. Shelf package: 25 boxes (500 units). Case: 2 shelf packages (1000 units).

B-D CONTROLLED your assurance of sterility

On all sterile, disposable DISCARDIT products, B-D supplements federal sterility controls by introducing with each product lot undergoing sterilization, red-marked products contaminated with organisms known to be resistant to the sterilizing agent. B-D passes production lots only if post-sterilization tests establish the sterility of both regular product samples and the extra red-marked control samples.

B-D **BECTON, DICKINSON AND COMPANY · RUTHERFORD, NEW JERSEY**

In Canada BECTON, DICKINSON & CO., CANADA, LTD., TORONTO 10, ONTARIO

PRINTED IN U.S.A.

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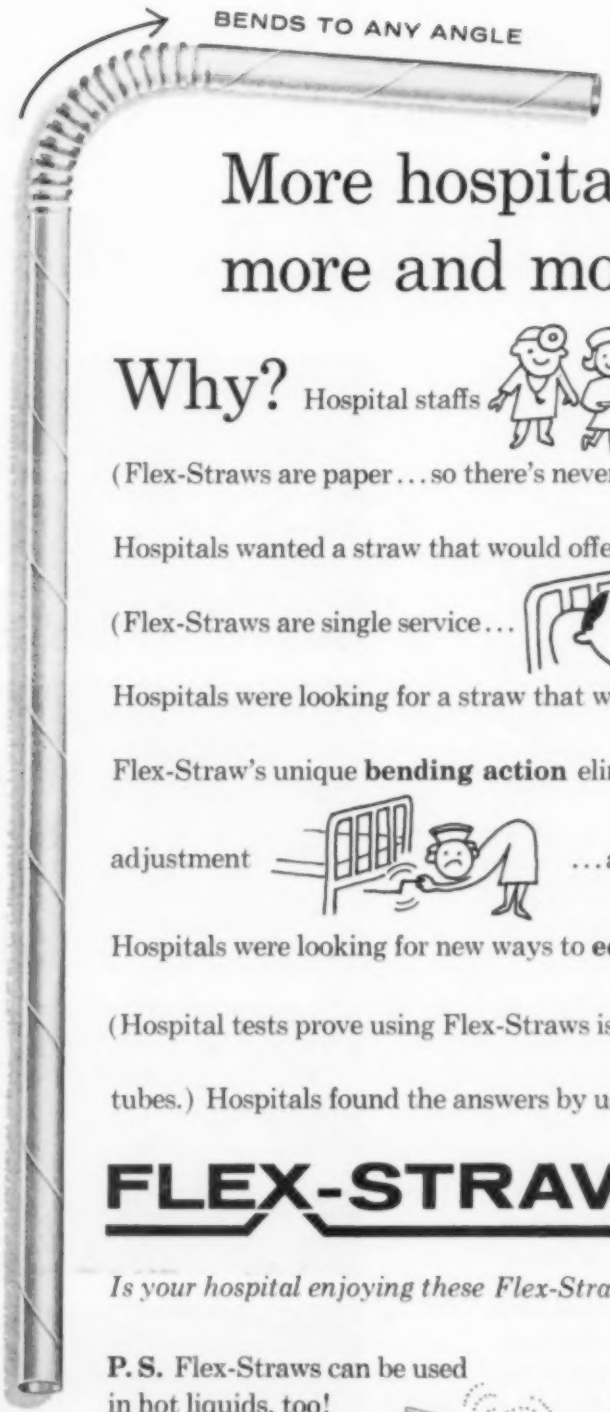

More hospitals are using more and more Flex-Straws!

Why? Hospital staffs wanted a straw that was **safe**

(Flex-Straws are paper... so there's never any danger of broken glass.)

Hospitals wanted a straw that would offer their patients added **cleanliness**

(Flex-Straws are single service...  they're always fresh as a daisy.)

Hospitals were looking for a straw that was **convenient** and **efficient**.

Flex-Straw's unique **bending action** eliminates lost motion in patient bed

adjustment ...and Flex-Straws are **disposable** too.

Hospitals were looking for new ways to **economize** 

(Hospital tests prove using Flex-Straws is more economical than using breakable tubes.) Hospitals found the answers by using...

FLEX-STRAWS®

Is your hospital enjoying these Flex-Straw advantages?

P.S. Flex-Straws can be used in hot liquids, too!

refer to
HOSPITAL PURCHASING FILE
for listings and prices

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Only American Cascade Unloading Washers have

"LOAD-LOK" CYLINDER DOORS

American has done it again!

Exclusive "Load-Lok" cylinder doors have greatly simplified one of the few remaining manual operations with Cascade Unloading Washers. Load-Lok Doors are unsurpassed in ease of operation, simplified maintenance and complete safety.

Easy to operate. A flick of the fingers releases latch at each side of door (Figure 1), and weight of door causes it to fold open into compartment (Figure 2). A simple push on bottom edge (Figure 2) latches door automatically in full open position, prevents any movement during loading and unloading.

Closing is just as easy. A slight push inward as latch is depressed (Figure 3) and door slides forward to half-closed position. A quick snap forward (Figure 4) and door automatically locks shut.

Simplified Maintenance. With no cylinder door bands and slides to adjust, repair or replace, and fewer expendable parts, Cascade Unloading Washers are easier than ever to maintain.

Complete Safety. Weight of door plus inward fold makes it impossible for door to close on operator's hand. Also, door cannot work loose during washing cycle, because the weight of the load in the compartment helps lock the door closed.

Labor-saving, high-production machines are the surest way to increased profits. For complete information on American Cascade Unloading Washer with exclusive Load-Lok cylinder doors, contact your nearby American Man from the Factory or mail coupon.

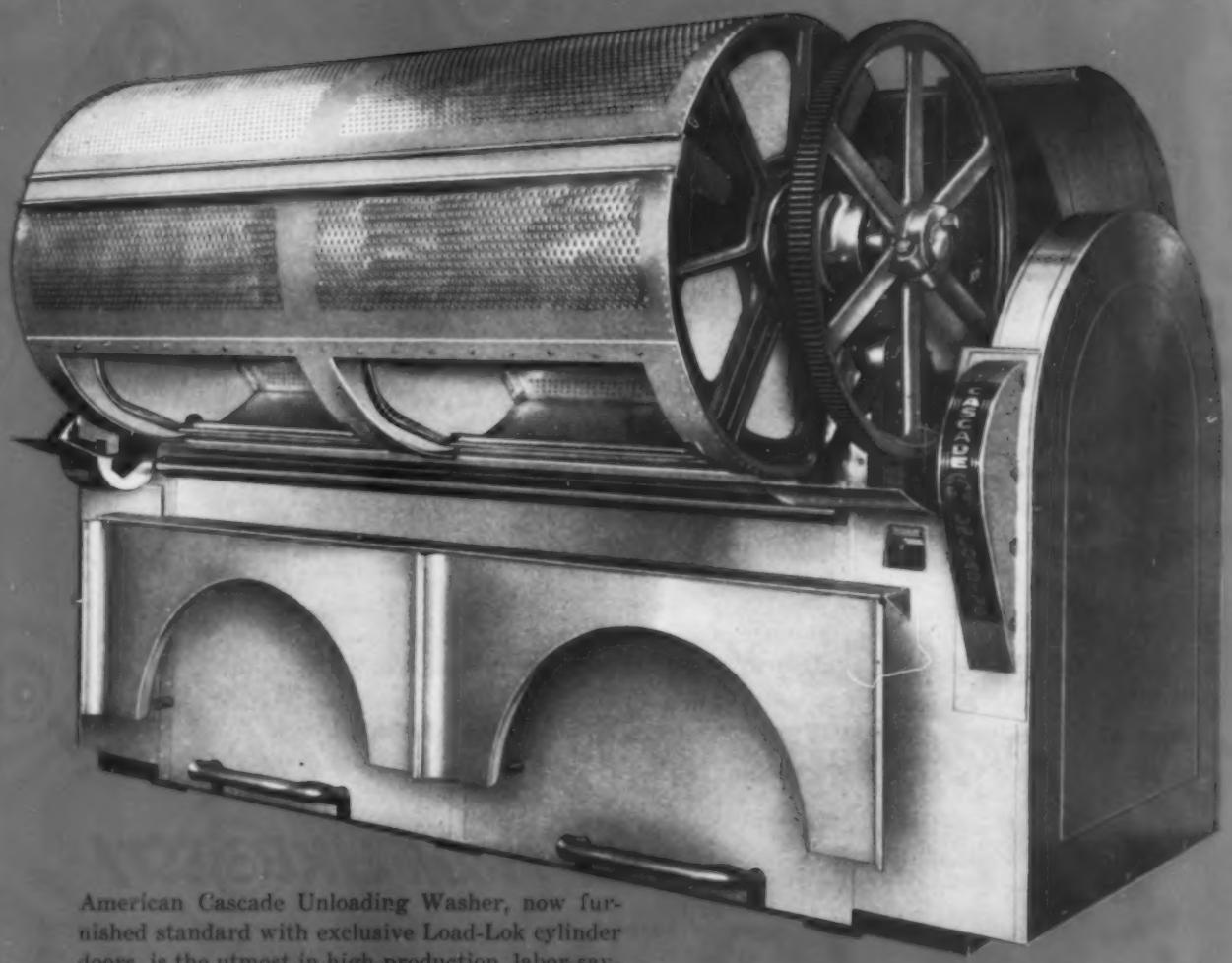
1

2

3

4

The American Laundry Machinery Company, Cincinnati 12, Ohio



American Cascade Unloading Washer, now furnished standard with exclusive Load-Lok cylinder doors, is the utmost in high-production, labor-saving laundry machinery. Automatic Washing Controls (furnished optional according to your particular requirements), and push-button unloading save labor, water and supplies, increase efficiency, allow each washman to handle more washers, and produce more washer loads per day.

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Here's the Soap that's

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O-CEDAR—a household word for cleaning efficiency—has put a half century of skill and experience into a new family of maintenance products.

Scientifically designed and formulated—O-Cedar's new line of industrial polishes, mops, brooms and cleaning aids do a faster, more effective job in hotels, office buildings, industrial plants and institutions. They're unmatched in quality—yet fully competitive in price.

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Long-wearing mops of fine quality yarn, with chrome-plated swivel sockets for fast, thorough cleaning. Washable pads snap on instantly. Widths: 24", 30", 36", 42".

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Available in 3 types with long wearing, water and grease resistant Permene bristles—Series 800 for garages, sidewalks, etc. Series 900 for all-around floor maintenance—Series 1000 for industrial and street use. Permene bristles wear longer . . . and are completely washable.

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Please send me complete information, pictures and prices on the new O-Cedar industrial cleaning aids.

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Now, in a sweeping move to reduce hospital costs substantially and provide faster, more efficient service, the Surgical Products Division, American Cyanamid Company, inaugurates a revolutionary DIRECT-PURCHASE PLAN!

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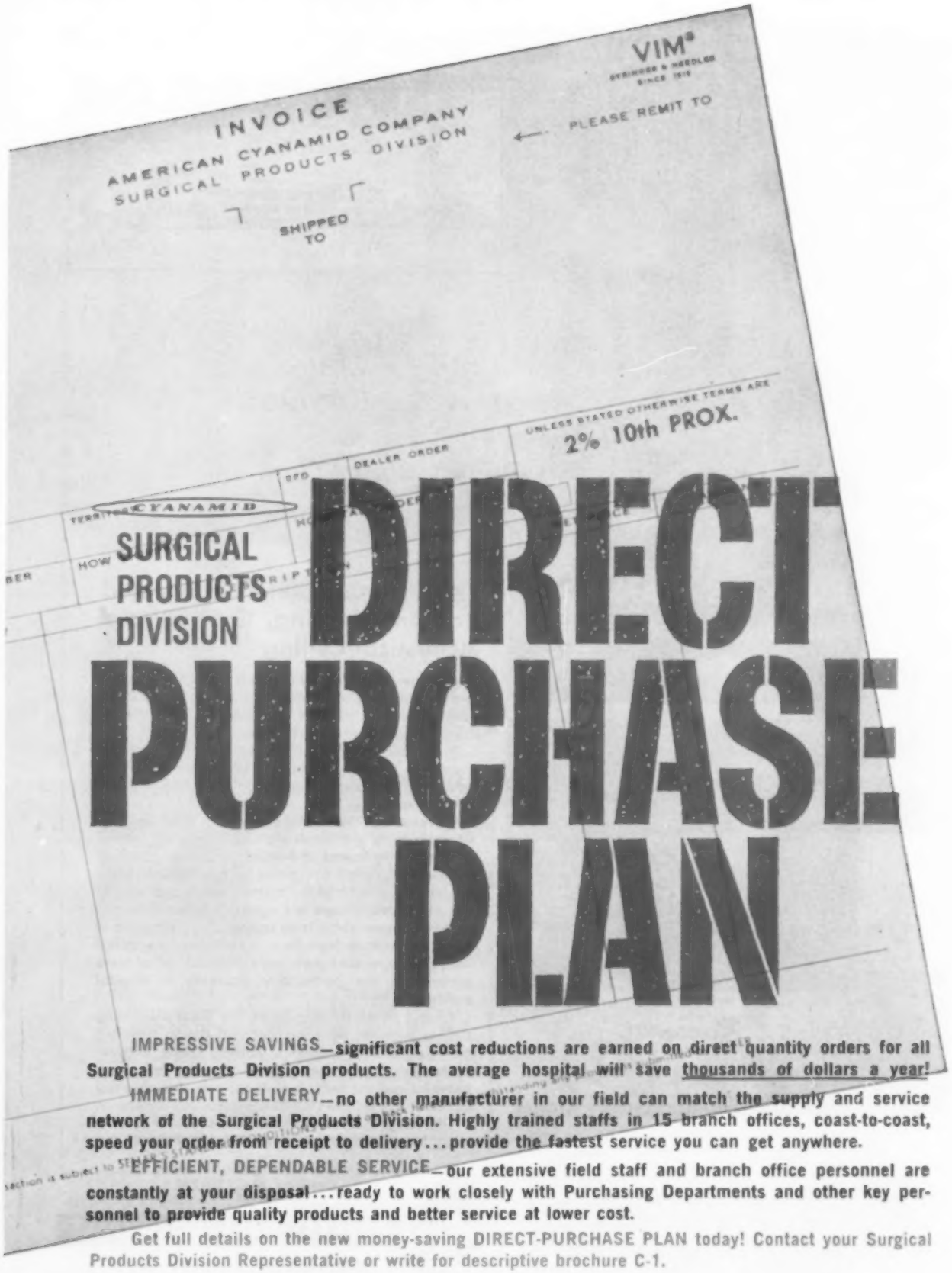
Your hospital can now purchase the finest and most advanced products in their field—D&G Brand Sutures, VIM® Brand Syringes and Needles, and a wide variety of surgical specialties—direct from the manufacturer.

The DIRECT-PURCHASE PLAN is a major step in our continuing program designed to bring you better products and more efficient service at the lowest possible cost. It offers your hospital important new benefits.



IMPRESSIVE SAVINGS—**significant cost reductions are earned on direct quantity orders for all Surgical Products Division products. The average hospital will save thousands of dollars a year!**

IMMEDIATE DELIVERY—**no other manufacturer in our field can match the supply and service network of the Surgical Products Division. Highly trained staffs in 15 branch offices, coast-to-coast, speed your order from receipt to delivery... provide the fastest service you can get anywhere.**

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Your Building Budget No Bigger

The Only Completely Integrated Radiant Heating, Cooling and Acoustical Ceiling

A Burgess-Manning Radiant Acoustical Ceiling completely comfort conditions a building winter and summer and, in addition, provides the best possible acoustic control to absorb noise.

It not only performs these functions but performs them with superior efficiency and economy, with no additional first cost and an actual reduction in maintenance cost.

Radiant heat, Nature's own method, has long been recognized as the more technically correct method of any known means of heating for human comfort. It is particularly advantageous for hopsital use. Since it is not dependent on air currents, unpleasant drafts are eliminated. Floors are always warmer than the air of the room—there is no appreciable difference in room temperature from floor to ceiling—concentrated heat sources or cold spots are eliminated. All of these advantages are particularly desirable in hospital buildings.

From a structural standpoint, the Burgess-Manning Ceiling provides more architectural design freedom, more useful floor area and building space. Because of its operational efficiency and the inherent advantages of radiant heat, fuel economies are obtained as well.

The Burgess-Manning Radiant Acoustical Ceiling might have been designed especially for hospital use.

Write for Burgess-Manning Catalog No. 138-2M

SEE OUR CATALOG IN SWEET'S ARCHITECTURAL FILE OR WRITE FOR COPY

3 Heating Cooling Acoustical

BURGESS-MANNING COMPANY

Architectural Products Division

5970 Northwest Highway, Chicago 31, Ill.

Serve your meals WITH Shampaine ELECTRIC

Super-Mealcart. (Design Pat. Pending) (S-3010-MR Illustrated 20 Trays with Beverage Bar S-3010)

SUPER-MEALCART

Represents the latest advance in efficient portable food service equipment for centralized tray systems. The famous step-down feature (design pat. pend.) provides work surface for set-up and beverage dispensing from exclusive removable beverage bar (S-3010). Large drawers with generous clearance allow room for half-pint milk containers and full complement of dinnerware. Drawer depth in hot side permits clearance for coffee cups. Coffee is dispensed from beverage bar into pre-heated cups. Available in *mechanical refrigeration* and *cartridge type refrigeration* models.

MECHANICAL REFRIGERATION MODELS

Mechanical refrigeration with hold-over cooling capacity for a full hour *without* running compressor or blower. Will hold and retain 38° F. even in room temperature of 90° F.

S-3001-MR	(20 trays)
S-3002-MR	(24 trays)
S-3003-MR	(30 trays)

CARTRIDGE TYPE REFRIGERATION MODELS

(CARTRIDGES NOT INCLUDED)

S-3001-DP	(20 trays)
S-3002-DP	(24 trays)
S-3003-DP	(30 trays)

ONLY SHAMPAINE ELECTRIC SUPER-MEALCART HAS . . .

- an unobstructed set-up area *convenient* counter height, at 41" for 20-meal cart, at 44" for 24-meal cart. Accommodates large trays up to 15½" x 20½".
- all stainless steel, double-walled, fully-insulated construction throughout. 2½" insulation between hot and cold compartment.
- compact heated drawers accommodating three 9" dinner plates, *plus* three 5¼" plates, *plus* three coffee or tea cups
- an oven compartment with internal, waterproof installed, stainless steel, sheathed sealed heaters. Accessible *without* dismantling or turning cart upside down. Provides uniform temperatures (185° F.) throughout compartment.
- fully-insulated, recessed and double-walled doors of oven compartment close tightly against recessed frame. Full-length *stainless steel* piano hinges on doors.
- rugged, compact tray slides that can be removed in easy to clean *sections*, providing clearance between tray slides of 3¾" for ½ pint "carton-type" milk container.
- models in 20, 24 and *30-meal size, for both *mechanical* and *eutectic* refrigeration (Dole cartridge), and with or without beverage dispensers.

*at additional set-up charge.

S-3010 Beverage Dispenser
(Cart Not Included)

REMOVABLE BEVERAGE BAR S-3010

Removable, easy to load, easy to clean beverage bar with *separate*, individually insulated wells permitting dispensing of boiling water from one and cooled drinks from the other. Bar can be used in combination with utility truck for "between-meal" coffee or fruit juice servings to patients or can be set up in Doctors Lounge.

Electric, three well—each well individually thermostatically controlled, stainless steel.

SHAMPAINE ELECTRIC COMPANY, INC. *THE COMPLETE FOOD CONVEYOR LINE*

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a SHAMPAINE industry

THE TABLE OF TOMORROW—HERE TODAY...S-1501

SURG-A-MATIC BY SHAMPAINE

SURG-A-MATIC brings you many features that set new standards for major operating tables.

PUSH-BUTTON SHIFT—Ultra-convenient push buttons select all positions—conventional or extreme . . . including single adjustment proctoscopic, complete flex, reflex and kidney elevator. Push buttons eliminate visual attention.

TRUE HEAD-END CONTROL—All controls face anesthetist . . . outside draped and sterile field. Anesthetist remains seated. No search at sides of table to check indicators or reach controls.

NEW BASES—Motorized or hydraulic . . . with new features for smoother, easier operation. No external housings.

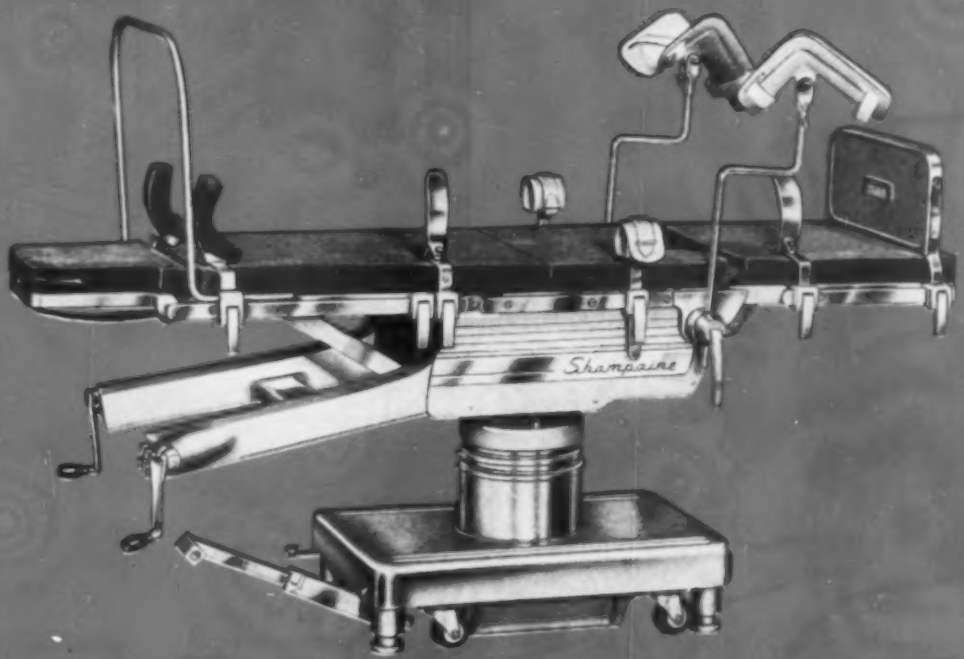
FAST ACTING SIDERAIL CLAMPS—Eliminate broken or easy-to-lose setscrews. Accessories attached or detached with minimum effort and time.

NEWLY DESIGNED CRUTCH SOCKETS—Quick acting friction lock clamps speed adjustment of leg holders. Self-locking socket holds rod in any position . . . sockets easily removed.

FEATURING EXCLUSIVE PUSH-BUTTON SHIFT

JUST PUSH A BUTTON AND TURN HANDLE AT RIGHT TO REACH ANY OPERATIVE POSITION

Left handle controls independent Trendelenberg adjustments (maximum Trendelenberg in 22 turns). See new Shampaine positions below.



Shampaine COMPANY

1920 S. JEFFERSON • ST. LOUIS, MO.

A SHAMPAINE Industry

SURG-A-MATIC provides table top heights from 27" minimum to 45" maximum.

SURG-A-MATIC provides kidney elevator adjustment off push-button shift.

SURG-A-MATIC provides complete 139 degree flex.

SURG-A-MATIC provides single adjustment proctoscopic position.

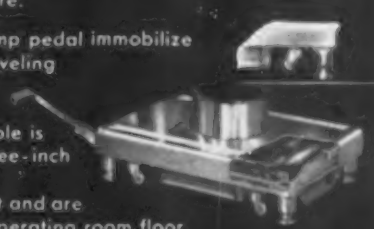
NEW BASES— MOTORIZED OR HYDRAULIC

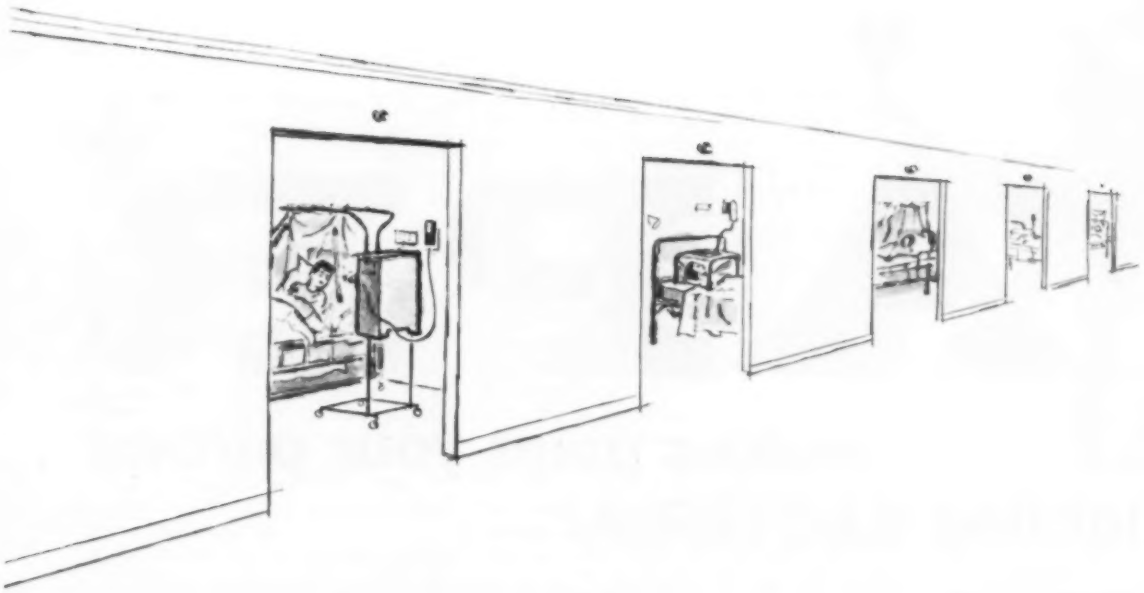
Table top is supported by three widely spaced rods within pedestal. They provide maximum support to eliminate lateral whip of table top. No exposed keyways.

Flat stainless steel shield has integrally formed footrests to eliminate crevices and assure easy cleaning.

Motor concealed in base—no external housings. Motor listed with Underwriters Laboratories for class "1" group "C" atmosphere.

Downward strokes of pump pedal immobilize table on hydraulic self-leveling floor jacks. Upward pressure on pedal retracts floor jacks . . . table is then on easy to move three-inch ball bearing casters. Jacks provide firm support and are self-leveling on normal operating room floor.





the seventh floor is quiet tonight

Miss Thorpe, the night nurse, is ahead in her charting. You can almost hear the clock tick, and all is well. On a post-surgery floor like this, practically a miracle.

One of the reasons for this moment of relief is the piped oxygen system. Miss Thorpe can rest assured that oxygen will continue to flow to her patients without fail.

Instead of an oxygen cylinder in every room, each needing replacing at a different time, there is a small outlet at the bedside, silent and constant.

Instead of the rattle of cylinder trucks, the clank of chains, the thump of cylinders being unloaded, the hiss of cylinder valves being "cracked" to terrify patients—there is a silent flow of oxygen, soothing and life-giving.

The quiet efficiency of this seventh floor is duplicated in hundreds of hospitals across the country equipped with NCG piping systems for oxygen, vacuum, and nitrous oxide.

Over 1800 hospitals piped with NCG piping systems. 139,523 individual outlets installed. NCG outlets are listed under the Re-examination Service of Underwriters' Laboratories, Inc.

Now that oxygen is routinely prescribed for patients after surgery, piped oxygen is a necessity. For plans and figures for piping your hospital—new or old, complete or partial—call or write your nearest NCG office today. Offices in 56 cities.

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TRADE MARK

makes paint your partner in fighting BACTERIA!

Yes, the dangerous disease-causing bacteria are held in check after contacting walls and ceilings painted with paints containing APR. This remarkable anti-microbial process reduces risk of cross infection from painted surfaces. In hospitals, food processing plants, dairies, bakeries, breweries, institutions, for business and industry . . . wherever people gather for work, study and play . . . the unique anti-microbial action of APR in paints is a valuable germ-fighting aid.

The anti-microbial effectiveness of the painted surfaces covers an extraordinary wide bacterial spectrum and lasts for the practical life of the paint film. Fungicidal paints with APR effectively control mold and fungal growth on painted surfaces.

APR IS SAFE—Surfaces coated with paints containing APR are safe and non-poisonous.

APR IS PERMANENT—The germ-proofing action of APR is residual throughout the paint film, even after washings and scrubbings.

APR SAVES YOU MONEY—Helps protect products and personnel. Cuts maintenance costs. Eliminates need for frequent disinfectant washings of walls and ceilings.

TOP QUALITY PAINTS . . . *PLUS* APR

- Easy to apply with brush or roller
- Dry in minutes
- Tough, scrubbable, durable
- No painty odor
- Wide range of decorator colors, plus white; dry to a velvet finish
- Excellent hiding power

PAINTS WITH APR COST NO MORE THAN OTHER FINE PAINTS!

QUALITY CONTROLLED YORK RESEARCH CORPORATION

The anti-microbial, bactericidal, germ proofing and fungicidal properties of paints with APR have been tested and proved by public authorities, universities, hospitals, industries and independent laboratories the WORLD OVER.

PAINTS WITH APR WORK WITH YOU AND FOR YOU, FIGHTING GERMS ON ALL PAINTED SURFACES . . . TODAY . . . TOMORROW . . . MONTHS FROM NOW . . . YEARS FROM NOW!

These are the fine brands of paint with APR:

ACKRA WALL with APR	Irwin Paint Co., Inc., Berkeley, Cal.
DECOR-X with APR	Breinig Brothers, Inc., Hoboken, N. J.
DURASATIN with APR	Dixie Paint & Varnish Co., Inc., Brunswick, Ga.
FUNGI-CHEK with APR	Charles Bowman & Company, New York, N. Y.
RYLON-X with APR	West Paint & Varnish Co., Boston, Mass.
SATIN-X with APR	Jones-Blair Paint Co., Inc., Dallas, Texas
SUPER-ONE-ALL with APR	Olympic Paint & Varnish Co., Los Angeles, Cal.
WAL-SHIELD with APR	M. A. Bruder & Sons, Inc., Philadelphia, Pa.

Choose from two types of paint with APR—anti-bacterial and anti-fungal, to withstand conditions of condensation or humidity. Ask your supplier for the correct one to fill your requirements.

*Anti-microbial Process Reagent by Dentolite Formulae.

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SMALL HOSPITAL QUESTIONS

Do We Need Pharmacist?

Question: How many beds (patients) are required to justify employment of a full-time registered pharmacist?—M.M.C., Neb.

ANSWER: The exact number is in dispute; administrators of some hospitals having as few as 50 to 75 beds insist it is not only economic but in the interest of better patient care to employ a full-time pharmacist. Others prefer an arrangement with a pharmacist who divides his time among several hospitals, or employ a pharmacist-consultant—often the retail pharmacist in the hospital community. These arrangements have been reported as satisfactory and economical for small hospitals.

In a recent survey, hospitals replied as follows to the question, "Do you have a full-time pharmacist?": Among hospitals having fewer than 50 beds, 12.5 per cent reported having full-time pharmacists; five years ago, only 6.5 per cent of hospitals in this group had full-time pharmacists. Twenty-six per cent of hospitals having 51 to 100 beds had full-time pharmacists, it was reported in the current survey, compared to 19.9 per cent in this group five years ago. Seventy per cent of hospitals from 101 to 200 beds had full-time pharmacists; 90 per cent of hospitals from 201 to 300 beds had full-time pharmacists, and 93 per cent of hospitals over 300 beds had full-time pharmacists; in these larger size hospitals, the number having full-time pharmacists had not changed substantially in five years, it was reported.

Pay Bills Before Readmission?

Question: How should the readmission of a patient be handled when there is an unpaid balance on the bill for the previous hospitalization?—D.P.S., Idaho

ANSWER: In an emergency, no question should be raised about admitting a patient because of the unpaid bill, though certainly the unpaid account may be called to the attention of a responsible member of the patient's family at this time as long as admission and needed service are not delayed. For elective care the admission may be conditioned on payment of the unpaid account, or, if this seems an unreasonable demand under the circumstances, the hospital may ask the patient or responsible family member to sign a note for the unpaid balance, make an assignment of wages or insurance, or some other satisfactory arrangement assuring payment of the previous account and the current bill. For a detailed discussion of accounts receivable, see page 65.

Income From Laboratory

Question: What percentage of the hospital's total income should be derived from laboratory charges?—J.W.C., Ill.

ANSWER: These charges should not be established on a percentage-of-income basis but on laboratory costs for the various procedures, plus a reasonable amount to cover contingencies. Generally speaking, laboratory expenses may be expected to aggregate 5 to 6 per cent of total hospital expense.

Who Should Tell the Press?

Question: Who is responsible for releasing information about patients to the press?—B.I.H., N.Y.

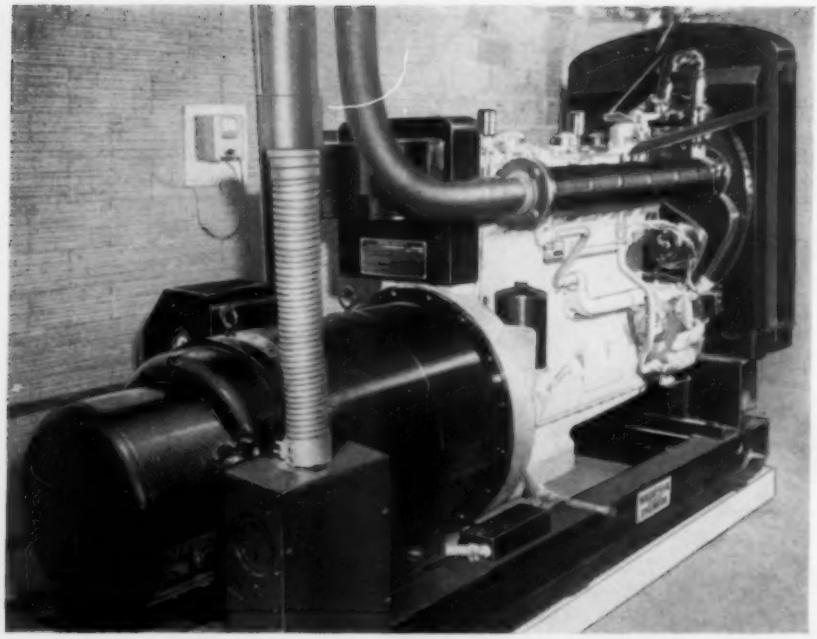
ANSWER: Detailed questions about the condition of any patient should be answered only by the attending physician and in any event this information may be released only with the consent of the patient or a responsible family member. General questions, such as verification that a patient has been admitted to the hospital and an evaluation of his condition as "critical," "satisfactory," "not serious," may be answered by the administrator or his representative, who may also add information—again with the consent of the patient or a member of the family—about the nature of the illness or injuries. In keeping press relations satisfactory, it is important for the hospital or hospitals to have an understanding with the newspaper or newspapers in the community about the kinds of information that can be released under various circumstances, and it is important for some one named person to be available at all times to release the kind of information that has been agreed upon. The most common complaint newspapers have about hospitals is that their inquiries—particularly at times when the administrator's office is not covered—get transferred from one person to another, and nobody is authorized to release any information at all. With a little planning, it is not difficult to provide the information newspapers want without violating any patient's right to privacy.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Emergency Room Assignments

Question: There is a conflict within our medical staff about assignments to emergency room service. The by-laws provide only that the chief of staff shall make the assignments, and the chief has assigned staff members mainly from a particular group on the staff, passing over some of the best qualified men, who have objected. As long as the assignments are being made in accordance with staff by-laws, is there anything the administration or board of trustees can do to correct the situation?—A.S.A., R.I.

ANSWER: Assuming that all efforts to persuade the chief of staff that the rotation should include all qualified staff members who wish to be assigned to emergency room service, and that appropriate steps to amend the by-laws have been undertaken, so that emergency room assignments will be made by the executive committee of the staff, or some other group representing the entire staff, if the conflict is still so serious that it threatens to disrupt the staff before these measures can take effect, the only recourse the board might have under these circumstances would be (1) to terminate the chief's appointment and select a new chief, if this is permissible in the by-laws, or (2) terminate the existing staff organization and reorganize the staff, under new by-laws providing a more satisfactory method of assigning emergency room service. The latter method, obviously, would be a last resort and should be considered only if the present conflict is actually threatening disruption of the staff.



HOW ST. MARY'S 230 BED HOSPITAL RACINE, WIS. IS PROTECTED

IN AN EMERGENCY—
electric service
for this hospital
is supplied by

WAUKESHA ENGINATOR®

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Automatic, Immediate Service

For — essential lighting . . .

surgery suite . . . laboratories

. . . X-ray . . . dietary . . .

boiler rooms . . . emergency elevators

. . . and ancillary equipment

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WAUKESHA • WISCONSIN
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This engine-driven electric generator combination—the Waukesha Enginator—is a complete power package. It stands ready to supply a smooth, steady flow of electrical energy for the hospital emergency service circuit, at any time.

The Enginator shown here is Model 145-GZB—100 KW or 125 KVA, 120/208 volts—operating at 1800 rpm. It is a combination gas-gasoline unit. Basically its engine uses natural gas fuel. Should the gas pressure fail, it *automatically* starts operating on gasoline.

Developed by over 50 years' experience in building heavy-duty internal combustion engines and electrical equipment, Waukesha Enginators have a world-wide proven record of reliability. Made in Diesel and carburetor fuel models, up to 800 KW capacity. Send for descriptive literature.

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Solid Vinyl Flooring

protects itself from any kind of traffic

The beauty of Bolta-Floor solid vinyl is obvious . . . It has natural lustre, rich colors, authentic patterns. But Bolta-Floor's hidden values count even more. Its smooth non-porous surface can be kept fresh and new-looking with far less care even in areas that take a daily beating. Bolta-Floor lays-up square and tight, remains dimensionally stable with no unsightly seams that catch dust and dirt. Bolta-Floor is resilient, recovers quickly from indentation, is quiet and comfortable underfoot. Once you've seen these hidden values demonstrated, you'll join the thousands of performance-minded owners, architects and builders who now specify BOLTA-FLOOR. Write us today for the full story.

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The finest quality flooring for

■ Stores ■ Restaurants ■ Motels
■ Hospitals ■ Offices ■ Homes

Bolta Floor® GENERAL® PLASTICS
The General Tire & Rubber Company

***Bolta-Floor** is available in a full range of solid colors, marbleized and terrazzo patterns in all practical gauges, tile sizes and roll widths. See Sweet's Architectural File 13i/Ge.*

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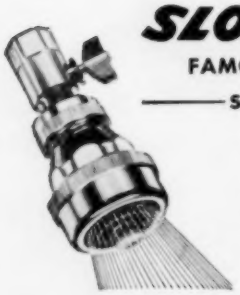
• The new $6-million, 40-story EXECUTIVE HOUSE, soon to be completed in downtown CHICAGO, bears the distinction of being the tallest reinforced concrete building in the U. S., and the first hotel to establish a new concept in operations. Approximately half of its 448 units will be leased to business firms to accommodate out-of-city clients or company representatives who make frequent business trips to Chicago. Suites consist of studio-living room, kitchenette, bath and shower. Larger units include bedroom. All areas throughout the building will be comfortized by a combined heating and cooling system. The building is sheathed in stainless steel and glass, and nearly three-fourths of the units will have private balconies. As are thousands of other great buildings, this remarkable hotel structure is completely equipped with SLOAN *Flush* VALVES.



SLOAN *Flush* VALVES

FAMOUS FOR EFFICIENCY, DURABILITY, ECONOMY

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Another achievement in efficiency, endurance and economy is the SLOAN *Act-O-Matic* SHOWER HEAD, which is automatically self-cleaning each time it is used! No clogging. No dripping. Architects and Engineers specify, and Wholesalers and Master Plumbers recommend the *Act-O-Matic*—the better shower head for better bathing.

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wire from Washington

HILL-BURTON EXTENSION

There is only one thing certain about the Hill-Burton program in Congress this year—it will be extended. The extension likely will be for two years, but it might possibly be for three.

These were the only concrete results from four days of hearings on the program before Chairman John Bell Williams' health subcommittee of the House interstate and foreign commerce committee, where a parade of witnesses urged extension for from two to 10 years, and proposed a score of amendments that would drastically alter the operation.

Mr. Williams, near the close of the hearings, suggested a simple two-year extension for two reasons. First, as explained by the chairman, a series of amendments proposed by the Department of Health, Education and Welfare wouldn't be ready for action until the end of May at the earliest, which might mean the extension, if combined with controversial changes, would be endangered because of adjournment. Second, although Mr. Williams didn't mention this, a fear persisted that anything but a simple extension bill might attract the Powell amendment in the House. This amendment would deny grants to any hospital that practiced racial segregation.

The segregation issue exploded into the open during the hearings on Hill-Burton, when two witnesses for the Physicians' Forum, organized more than 10 years ago to support national health insurance, testified before Mississippian John Bell Williams.

The two complained that segregation was practiced in Hill-Burton hospitals in the South, and that Negro patients were discriminated against in facilities and medical care. They called on the subcommittee to knock out of the Hill-Burton Act a provision that hospitals need not be integrated if facilities were "separate but equal."

After a long and bitter exchange between Mr. Williams and the two witnesses, they were asked if they would oppose extension of the act even if the "separate but equal" provision were retained. They said they would not.

Not a single witness opposed extension of Hill-Burton, and none proposed that its authorization be cut. Several wanted it extended more than two years. Mr. Williams favored two years, explaining that this would give each Congress an opportunity to review the program before voting to continue it.

Suggested changes, many of them in conflict, poured in on the subcommittee. All are under study, and the subcommittee expects to work some of them into a bill and send it along later, in the hope that it, too, as well as the extension, would go through before adjournment.

The American Hospital Association (witness, Dr. Robin C. Buerki) wants a five-year extension and the following changes, among others: at least $75 million a year for a separate category of grants exclusively for renovation and modernization; higher authorization for grants in all categories, and in addition long-term loans with no interest or very little, directly from the federal government; states authorized to shift funds among various categories; a special fund of $5 million to be divided among states with abnormal population growth; an increase in the present $1.5 million for research.

Among American Medical Association's recommended changes are the following: elimination of both diagnostic-treatment and public health centers from benefits, as there is little evidence of a need for these "ill-defined" former units and a very few states are getting most of the money for the latter; eliminate the mandatory priority given rural communities, as great progress already has been made in meeting their hospital needs; a shift in emphasis toward facilities for the chronically ill and nursing homes, and toward modernization and renovation of old hospitals; greater latitude for states in establishing priorities and allocating funds; elimination of all categories and substitution of one single appropriation for all facilities, thus making better use of total money.

A.M.A.'s recommendations were based on a 14 state survey on which association staff people have been working for more than a year.

The Department of Health, Education and Welfare gave a general outline of some of the changes it proposes. Its spokesmen said detailed amendments would be sent along later. While many H.E.W. suggestions paralleled those of A.H.A and A.M.A., there were some new ones and some conflicting ones: a three-year extension with no change in grant authorizations, but $5 million a year rather than $1.5 million for research and demonstration; a consolidated chronic disease-nursing home category, with more money; delete the requirement that a sponsor of a diagnostic-treatment center be either a public agency or a nonprofit agency "that owns and operates a hospital," as many competent organizations do not "own and operate" hospitals; authorize states to use up to 4 per cent of their construction allotments for advance planning when this advance would speed up construction and help fight the recession.

STAPHYLOCOCCUS RESEARCH

A Senate hearing on appropriations for H.E.W. gave American Hospital Association a convenient forum for presenting a well rounded summary of the history of staphylococcal infections, the present status, and prospects for the future.

The witnesses were Drs. August H. Groeschel and Frederick H. Wentworth, who represented the A.H.A. committee on infections within hospitals. They said many U. S. hospitals already have had serious problems with the infections, which are a potential danger to all hospitals and are in fact a worldwide threat.

Other observations from the A.H.A. team:

There are "innumerable strains" of staphylococci capable of producing infections, many susceptible to antibiotics, some resistant. The resistant strains, of course, present the main difficulty. "Antibiotic resistant staphylococci are largely a by-product of the widespread use of antibiotics which eliminate the susceptible strains and leave uncontrolled the resistant strains. . . . Antibiotic resistant staphy-

lococci are now producing infections in increasing numbers."

Hospitals "are clearly the principal reservoir of most antibiotic resistant strains." Strains from the community generally are sensitive to antibiotics, but patients who acquire resistant strains in hospitals "are potential spreaders of them to the community after discharge."

As to the future: "The incidence . . . is not known, and much too little known about the organism, nature of human resistance, mode of transmission. The effects of environmental conditions are generally unassessed. A great deal of study will be required to provide answers. . . ."

What is being done?

The A.H.A. committee on infections within hospitals, headed by Dr. Dean Clark, will shortly issue a report advising hospitals of the serious nature of the problem and suggesting prevention and control measures.

All hospitals have been urged by A.H.A. to establish committees on infections, and A.H.A. has also asked the Joint Commission on Accreditation of Hospitals to require such standing committees.

A.H.A. also has urged hospitals to start or participate in community control programs, in which medical societies, local health departments, and other groups will cooperate.

State health departments are being urged to expand laboratory services to facilitate proper identification of staphylococci for hospitals.

The A.H.A.'s own research department is developing a project on the epidemiology of infections in hospitals.

Turning directly to the rôle of the federal government in controlling the new and difficult infections, A.H.A. asked the subcommittee to approve an extra million dollars for the National Institute of Allergy and Infectious Diseases to be used exclusively on staphylococcus research, and an additional half million dollars for use by the P.H.S. Communicable Disease Center for field studies, control activities, and grants to state laboratories to allow them to expand.

NURSING HOME LOANS

The American Nursing Home Association is making a concerted effort to have Congress set up a program of loans or mortgage guarantees that would be available to proprietary as well as public and nonprofit institutions.

Under the Hill-Burton program, proprietary institutions are not eligible for help. A few small programs offer them some assistance in getting loans, but all are handicapped by lack of capital, limitations on extent of loan, or too high interest rate.

George T. Mustin, past president of the association, described the plight of the profit making nursing homes to a subcommittee of the Senate banking and currency committee.

He said the usual type of commercial loan is unsatisfactory because bankers will not accept the single-purpose buildings as good risks. He made these other points:

1. **Proprietary homes** care for 71 per cent of all aged ill and chronically ill and "there is no expectation whatever" that public or nonprofit institutions can take over the load.

2. **The nursing homes,** small, private, tax paying businesses, are not asking for federal subsidies; they will pay interest and repay loans.

3. **Homes with realistic standards** and proper arrangements for nursing and physician services, "serve hundreds of thousands of elderly patients who otherwise would be forced to enter general hospitals and pay the relatively high prices that hospitals are forced to charge."

NEW SECRETARY

Arthur S. Flemming, who takes over this summer as successor to H.E.W. Secretary Marion Folsom, is, like Mr. Folsom, a veteran of government service, both as a salaried official and a consultant. He has been involved with federal government in one way or another since his appointment by President Roosevelt as Republican member of the Civil Service Commission. He is a past director of the Office of Defense Mobilization and has served on numerous commissions and committees. He is regarded as a "modern" Republican.

NOTES:

Following the lead of Chairman Olin Teague (D.-Tex.) of the House veterans affairs committee, the American Legion has assailed the Bureau of the Budget for "arbitrarily" forcing Veterans Administration to close out about 5000 beds. The bureau's theory is that the government is required to provide medical care for service-connected cases only and that others are optional. The bureau thinks the service-connected case load would represent about 40,000 beds. The Legion, on the other hand, urges that VA maintain 140,000 beds.

Unless either house passes a motion of disapproval, on July 1 Federal Civil Defense Administration will be merged with the Office of Defense Mobilization in an organization to be known as the Office of Defense and Civilian Mobilization. Of importance to hospitals, all medical functions of the present F.C.D.A. would undoubtedly be assigned to U.S. Public Health Service. So far the indications are that Congress won't interfere and that the merger will be allowed to become effective.

Conference Favors Listing of Nursing Homes by A.H.A.; Some Members Advise Postponement

CHICAGO.—Immediate listing of nursing homes by the American Hospital Association was recommended by two of four discussion groups which considered the care of patients with long-term illness in Chicago, May 7 to 9.

The conference, attended by 46 representatives of hospital, medical, public health, and related organizations, was sponsored jointly by the American Hospital Association and the Public Health Service.

One of the discussion groups came out flatly against listing of nursing homes in the foreseeable future, while the fourth group felt that listing is "a legitimate area of interest for the A.H.A.," but added that the mechanics would have to be worked out.

Four areas of activity which the A.H.A. might pursue were considered. Each group explored one of the areas in depth and the other three as time permitted. They were:

A. Development of studies to gather further information from facilities providing care for the long-term patient.

B. Preparation of guides for the administration of services for the long-term patient in hospitals and related facilities.

C. Encouraging development of optimum relationships between hospitals and facilities other than hospitals in order to promote optimal care of the long-term patient.

D. Development of an A.H.A. program of service to facilities, other than hospitals, which provide care for patients with long-term illness.

Dr. Irvin J. Cohen, deputy director for hospitals of the Veterans Administration, was chairman of Group I, which considered question A in depth. There was general agreement among

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LOOKING AROUND

Doc's Disciples

CUT down operating and delivery room traffic and you cut down the number of hospital acquired staphylococcal infections, the authorities on infection have been saying. "Eliminate all unnecessary entries into operating room," say the oracles at the Public Health Service's Communicable Disease Center, and hospitals have been trying hard to make the rule stick.

Recently another kind of oracle let loose another view on the subject, and it couldn't have come at a worse time. In one of his syndicated newspaper columns a few days ago, Dr. William Brady, who often refers to himself as Old Doc Brady, and no wonder, angrily denounced the "contemptuous, patronizing, officious, arrogant, overbearing behavior of doctors, nurses, superintendents and every other hospital authority." The reason Old Doc was teed off, he explained, was that some mothers reported their husbands were excluded from hospital delivery rooms when they were having their babies.

Old Doc has advised parents to bite back when hospital authorities say husbands may not enter the delivery room. "Don't let them push you around," says Doc.

One husband who followed Old Doc's system got himself caught in the backlash last month when a superior court judge in Seattle ruled that he had "no contractual right" to be with his wife during childbirth in a Seattle hospital. Excluded from the delivery room at Group Health Hospital, Clifford A. Stone, the father, had sued the hospital, the obstetrician, and the director of a cooperative prepayment plan, claiming the exclusion was an invasion of the privileges of husband and wife at a vital time.

The court ruled for the hospital, denying that any rights were involved and adding that the court had no authority to regulate the practice of obstetrics in hospitals.

Unquestionably, it is desirable on many occasions for husbands and wives to be together when their babies are being born, but not at the hazard of infection that might endanger the lives of mother and baby. It seems likely that the nature of the infection hazard is understood better by the contemptuous, patronizing, officious, arrogant, overbearing doctors, nurses and superintendents than by the average prospective father—or even by Old Doc Brady.

The court thought so, at any rate, and hospitals now have legal ground for raising the bars against Doc's disciples when it seems advisable.

Autopsy

IN A recent communication to colleagues, Dr. E. M. Bluestone, as moral a medical man as ever learned the names of the long muscles, confessed a medical sin of many years ago which has been on his conscience ever since. Or has it?

"Now it can be told," said Dr. Bluestone; "all the actors in this little drama have been gathered unto their fathers. Once upon a time (thirty-five years ago, to be approximately correct) a man died on the wards of a great American hospital, where I was associated with a pioneer hospital executive of great renown. The entire medical staff descended on me as if their very lives depended on my ability to obtain legal consent from his family for postmortem examination, so, though I needed no prodding, I went to work on the family.

"Hour after hour passed as both sides stubbornly persisted. I knew from experience that such things take time and I was nothing if not patient. However, at twilight, when my eloquence began to give out I decided that I had met my equal and so reported to the staff. At nine o'clock the pathologist visited me and told me not to worry over my failure to get this one. 'Come with me,' he commanded, and led me to the postmortem room, where, for the first and only time in my life, I stood fascinated at the spectacle of a stolen autopsy.

"With the help of one small incision, placed in an invisible and forbidden location where no one would think of looking, the pathologist soon had his entire arm, up to the axilla, inside the man and skillfully managed to extract everything, including the tongue—the liver coming away in several pieces. A lot of teaching followed and the patient thus achieved more for others in death than he was able to do in life.

"The next morning hell broke loose for me, but not from the family or an unknowing mortician. The 'house' had signed the patient out as 'purpura hemorrhagica,' and the certificate bounced back to the office of the medical examiner from the department of health. A good friend of mine was assigned the case and, knowing my prowess in securing consents from difficult families informed me, with some glee, that he would cooperate and do this one himself. I was horrified as I pictured in my mind his findings after making his characteristic incision from pole to pole, and

tried gently to dissuade him from his purpose. I pleaded. I set forth every argument I had learned from experience with stubborn relatives and, as my syllogisms poured forth in a crescendo of effort, a strange look passed over his face. He listened incredulously, and finally he burst forth in shocked surprise. 'Are you sick?' he cried. I was, beyond doubt, in a tight spot and brought my argument to a climax by telling him that the great pathologist himself did not consider a postmortem examination necessary in this case.

"At this point my friend seemed to relax. With a twinkle in his eye, he desisted and signed the man out. The case was not reopened.

"Happily, we remained good friends till the end of his life. The subject was never discussed between us after that. At the time I did not quite realize the strength of the punch-line which decided him, but I am sure that I do now."

Peasants or Partners?

THERE are many ways to think about the Pennsylvania insurance commissioner's adjudication in the Blue Cross rate case (see next page). Informed opinion about the ruling and its significance for hospitals and Blue Cross ranges all the way from one group which believes the adjudication is unconstitutional and the commissioner is out of his mind to another which sees this pronouncement taking its place in a progression of events that will lead inevitably to consideration and treatment of Blue Cross and hospitals as public utilities, subject to systematic inspection and regulation by public bodies. If the latter view proves correct, it isn't going to make much difference whether hospital and Blue Cross people consider such regulation good or bad—and there isn't much doubt about what most of them think. Few groups that are subject to public control got there because they wanted public control.

Leaving off consideration of how bright or well informed the commissioner is, whether Blue Cross is a proper agency for the state to choose through which to exercise its control of hospitals, and whether the particular methods specified in the adjudication will achieve the control that is sought, or accomplish anything at all, it may be instructive to examine the reasons we have come to a point where it is now regulatory law in one of the largest states in the union, at least until a court says it isn't, that the rates charged by private hospitals—and hence the costs of hospital operation, and hence hospital operation itself—are subject to control by an official of the state.

Unquestionably, the principal reason, in the commissioner's own words, was that, "I do not believe that everything has been done to bring about the most efficient and economical management of our hospitals. . . . I do not believe that everything has been done by hospital administrators, by the Blue Cross organizations, and by the medical profession to eliminate unnecessary admissions and to reduce protracted hospital stays." Reading the testimony at the hearings, and the adjudication itself, one must conclude that the commissioner wasn't just talking. Hospital representatives testified that they had heard about, but never actually tried, many cooperative measures that some authoritative witnesses said offered promise of achieving substantial economies; they had heard about, but never investigated, methods used by one hospital to cut down unnecessary admissions and shorten stays; doctors knew about, but never did anything to eliminate, abuses of Blue Cross contracts. To the hospital administrators and doctors who testified, obviously, these failures seemed unimportant alongside the monumental task of providing care for the sick and injured around the clock—minor oversights compared to the awful responsibility that is their daily burden. But to the commissioner and the public the oversights looked like haughty indifference to the ever-mounting costs of medical care. Especially, the failure to act on abuses of Blue Cross contracts looked like downright fraud: "If doctors are admitting Blue Cross subscribers to hospitals where such hospital care is unnecessary, simply because the hospital bill will be paid by Blue Cross and the doctor is more likely to obtain his fee, grounds certainly exist for disciplinary action," the commissioner said, adding that the record showed one county medical society had done nothing but pass a resolution on the subject, and others had just done nothing.

Some observers have lamented the failure of the commissioner to say anything about the quality of medical service in hospitals, and the omission may indeed be significant of a lack of understanding of all that hospitals are striving to accomplish. But the adjudication seems aimed clearly at cutting down *unnecessary* costs and eliminating *unnecessary* utilization, and it is possible to believe there is nothing in it that implies or requires any sacrifice of quality.

In any event, the important thing here is not so much that the doctors and hospital administrators may have been right and the commissioner wrong, and that the economies and controls which will now be imposed by edict don't really amount to much in the whole, great, complex medical economy. The important thing is that the commissioner, and a large segment of the public, obviously thought the doctors and hospitals were wrong, and so the result was exactly the same as it would have been if they had in fact been wrong.

The way things have turned out, it isn't enough, as it was for so many years, for doctors and hospitals to be noble and right and, from atop Olympus, to tell the peasants only what is considered good for them to know. In our society today it is necessary to let the public in on the secrets, and then to perform in the largest possible measure according to what the public considers to be right. Any other course will lead, ultimately, to extinction for voluntary hospitals and private medicine, because the public, ultimately, gets what it wants.

Some hospitals in Pennsylvania, it is reported, consider that the insurance commissioner has usurped the powers of private corporations and are going to seek a court test of the adjudication's validity. This is a perilous move. In event the hospitals' position is upheld in court, the commissioner may then go to the legislature and ask for whatever powers he wants to regulate hospital costs and Blue Cross rates. With public opinion of hospitals and doctors in Pennsylvania where it stands today, judging from evidence presented at the hearings, it seems likely that the commissioner, or any other official of the state, could get whatever regulatory powers he asked for. If anything were needed to clinch the matter, nothing could suit the state's purposes better than a lawsuit aimed at getting hospitals out from under any kind of public control. However sincerely motivated, such an action will look like another maneuver to keep the peasants in their place. What is needed instead is an offer of partnership.

STATE SEEKS TO REGULATE HOSPITAL COSTS

Pennsylvania insurance commissioner's adjudication in Blue Cross rate case aims at control of hospital costs and utilization of facilities, establishing Blue Cross plans as agents of the state

Harrisburg, Pa.—Regulations seeking control of hospital costs and utilization of hospital facilities in Pennsylvania were set forth here last month in an adjudication of State Insurance Commissioner Francis R. Smith. The adjudication was made on a request for approval of subscriber rate increases by the Hospital Service Association of Western Pennsylvania.

Approving rate increases of 16 per cent for the Western Pennsylvania Blue Cross plan, which had asked for an increase of 21 per cent, Commissioner Smith included the Blue Cross plans at Philadelphia and Harrisburg in the adjudication, which provided for regulatory measures concerning hospital costs and utilization to be enforced through the Blue Cross plans as agents of the commissioner. Philadelphia was given a 40 per cent increase in rate, having requested approval of a 53 per cent increase, and Harrisburg received 20 per cent on a request for 29 per cent.

Following release of the adjudication here April 15, some Pennsylvania hospital representatives denied that the insurance commissioner had authority to regulate hospital operations to the extent implied in the ruling, or that the commissioner could delegate regulatory powers to Blue Cross plans. "The adjudication is unconstitutional," said one hospital official, who urged the state hospital association to seek an immediate court test.

The association took no action, but three hospitals in the Philadelphia area (Lankenau, Bryn Mawr, and Germantown) filed an exception to the adjudication as a first step toward seeking a court test of its validity.

The adjudication was based on extensive public hearings conducted by the commissioner in Philadelphia, Pittsburgh and Harrisburg, in connection with rate increases requested by the three plans. Testimony at the hearings covered every phase of Blue Cross and hospital operations, constituting what the commissioner called a "thorough reappraisal of the whole question of providing hospital care through nonprofit corporations." The hearing occupied 18 days and produced more than 3000 pages of testimony, it was reported.

"From this testimony and studies made by me, I am convinced that we should not resign ourselves to ever-increasing hospital costs and to unnecessary utilization of hospital services, and consequently to steadily climbing Blue Cross rates," said Commissioner Smith. "I do not believe that everything has been done to bring about the most efficient and economical management of our hospitals. In fact, I believe very little has been done. I do not believe that everything has been done by hospital administrators, by the Blue Cross organizations, and by the medical profession to eliminate unnecessary admissions and to reduce protracted hospital stays. In fact, I believe, with few exceptions, very little has been done."

To correct what he concluded were unnecessarily high hospital costs and excessive hospital utilization, the commissioner ruled:

1. Blue Cross plans must solicit assistance of hospitals, hospital councils, and other interested persons "in exploring all areas of hospital administration to determine where economies can be made."

2. Such studies must consider adoption of uniform accounting methods, joint purchasing, sharing of specialized equipment, standardization of costs among hospitals, more effective utilization of beds and hospital facilities, more effective use of personnel, and establishment of rooming facilities for ambulatory patients.

3. Blue Cross plans must inform hospitals of the results of these studies, and approval of the Blue Cross-hospital reimbursement formula for any hospital is conditioned "upon the actions of such hospital in putting into effect the plans and methods recommended to it by Blue Cross."

4. Where Blue Cross hospital payments include an amount for depreciation, this amount must be funded "so that these monies shall be used for the purposes for which they have been paid." Allocations for free care and new construction are to be eliminated from Blue Cross payments, and allocations for medical research and nursing education must be adjusted "to an amount commensurate with the services received by Blue Cross patients from such medical research and the operation of such nursing schools" at hospitals having such programs.

5. Blue Cross plans must inform their member hospitals of methods used by the Sacred Heart Hospital, Allentown, Pa., to reduce unnecessary hospital utilization by Blue Cross members (*i.e.* review of admissions and discharges, rules requiring prompt ordering of x-ray and laboratory tests, consultations), and approval of any Blue Cross-hospital reimbursement formula is conditioned "upon the actions of such hospital in inaugurating the beneficial features of the Allentown plan into such hospital's internal administration."

6. Blue Cross plans must allocate to administrative expense sums of money "sufficient to maintain constant vigilance over the progress of hospitals in instituting reforms to eliminate abuses in the use of hospital care."

7. Blue Cross plans must make further research studies into methods and means of eliminating abuses in

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Ray M. Amberg, left, administrator, University of Minnesota Hospital and president-elect of A.H.A., chats with Joseph G. Norby, hospital consultant and past president of A.H.A., at the Tri-State Assembly.

Administrators divide their time between problems of new and old hospital worlds.

Regional Conventions Draw Record Crowds

RECORD attendance and heavy thinking about the hospital's rôle in society characterized the regional hospital conventions last month. From San Francisco to Miami, hospital administrators, department heads, trustees and auxiliary members packed the aisles of convention meeting rooms to hear the nation's hospital leaders—as well as guests from industry, government, labor and education—talk about hospital functions and responsibilities that were considered out of this world by hospital people a few years ago.

Like the physicists, hospital executives have been taking readings in the outer space of the hospital world and, they have concluded, it won't be long before community hospitals will be performing as a matter of course such functions as home care, rehabilitation, progressive care, social service, nursing home care, and many other services that are closer to the moon than to the average hospital today. Like the physicists, too, hospitals were reminded by critics that they are in a race for control of this outer space; if hospitals themselves don't occupy the space surrounding present hospital functions, government will. Along with these heavy-duty concerns about new worlds, hospital executives at their spring conventions worried about tidying up the world they live in now—a world unhappily splashed with lawsuits, deficits and deadly staphylococci. While no magic formula appeared to wash away the stains, there was no question at the 1958 conventions that hospital people, assisted by a burgeoning hospital industry, felt equal to these and many other problems. Perhaps the best reason for optimism was the fact that, unlike many other groups, the hospital field was willing to face its problems and shortcomings realistically. "I doubt whether any group in the country undergoes more realistic and painful self-appraisals of its methods, procedures and personnel than do our hospitals," said an administrator at San Francisco.

The truth of this assertion was apparent in many "painful self-appraisal" sessions at the conventions. It is a truth that should give solid comfort to hospital people; a society that heeds its critics as well as its hallelujah shouters has little to fear for the future.

Howard Cook, left, Chicago Hospital Council's executive director, with John A. Reinertsen, assistant director of Evanston Hospital, Evanston, Ill.

Chicago.—With 8400 registrants attending sessions conducted by 36 separate sectional conferences, the 28th annual Tri-State Hospital Assembly broke out all over for three days here last month.

With so much going on, the Tri-State Assembly was perpetually in motion. At one point, the number of people who were reported going into meetings exceeded the total number registered, a circumstance plainly indicating that Tri-Staters were doing what they always do—going to one meeting for a few minutes, then getting up and going to another, and another. Tri-State behavior is hard on the feet and the speakers, unquestionably, but presumably it keeps the mind occupied and certainly it delights the exhibitors, who dote on what Tri-State has the most of—traffic.

When they sat still long enough, convention-goers heard and took part

in some significant discussions of current hospital problems. On at least one occasion, a hospital authority turned the tables on his audience by asking for advice instead of offering it. At the opening general session, Dr. Kenneth B. Babcock, director of the Joint Commission on Accreditation of Hospitals, said the commission needed help and ideas from hospital administrators in four areas of major concern. These are:

1. Establishment of criteria for the care of internal medicine patients. Especially, Dr. Babcock mentioned the need for standards governing isolation of patients and written procedures on the nursing care of medical emergencies.

2. Methods that will permit care of clean surgical and gynecological cases on obstetric floors. Under proper controls, it should be possible to provide care on OB floors for such things as clean minor gynecology cases, diagnostic D & C's, biopsies, clean abortions, fertility studies, diagnostic gynecology, medical gynecology, and clean major gynecology cases with the exception of cancer patients, Dr. Babcock suggested.

"What educational methods and control measures would you instigate before allowing this usage?" he asked. "We are anticipating that some day this nonsegregation of patients may be allowed under proper controls," he added.

3. Control of hospital infections. "Infections are bedevilling the medical and hospital professions and are a terrific concern to all conscientious hospital people," Dr. Babcock declared. "What ideas have you got to counteract infections?"

Hospital infection committees should not be just doctors' committees, Dr. Babcock suggested. Such committees should include nurses, administrators, housekeepers, dietitians and maintenance personnel, because, he said, "infections are a problem for everyone."

4. Prevention of malpractice actions against hospitals and doctors. Discussing accreditation problems generally, Dr. Babcock said that accreditation had to be a joint responsibility of the hospital board, administration and medical staff and cannot be forced on an unwilling staff. The Joint Commission should not become a licensing body, he said, although there is a possibility that some states eventually may refuse to license nonaccredited hospitals.

Another accreditation program—nursing—was the subject of a panel discussion following a presentation by Mildred Schwier, director of the National League for Nursing's department of diploma and associate degree courses, who acknowledged that the immediate cost of accreditation of a hospital school may be high but in-

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Leon C. Pullen, right, administrator, Decatur and Macon County Hospital, Decatur, Ill., and his assistant, Roy F. Erickson, at the Chicago meeting.

Administrators Emil Stahlhut, left, of Abraham Lincoln Memorial, Lincoln, Ill., and Paul A. Bjork of Community General in Sterling, Ill., take a break.

Left to right: Administrators Steve A. Lott, Hurley Hospital, Flint, Mich.; Marjorie Ann Sanders, McLaren General, Flint; Vernon Root, Community Hospital, Battle Creek, and D. Eugene Sibery, associate administrator at Crittenton General Hospital in Detroit.

Hospital of Future Will Take Its Services Out to the Community, West Coast Group Is Told

San Francisco.—The hospital of the future will take its service out to the community instead of waiting for the community to come and get it, Mark Berke, director of Mt. Zion Hospital and Medical Center here, said in an address at the 28th annual convention of the Association of Western Hospitals last month.

The convention drew a record-breaking registration of 5100, more than 1200 in excess of the previous high registration, Melvin C. Scheflin, executive secretary, reported.

What hospital services are in the future will be determined, not by doctors and hospital administrators and trustees, but by the public, Mr. Berke said.

"It is the patient who will determine what the hospital's future is to be," he declared. "It is the public which will decide what services it wishes us to provide, and what relationship shall exist between hospital, physician and patient, and what legislation is required to bring about this relationship. What we must do is provide the leadership, analyze the needs of the public, recommend the best methods to meet those needs, and then try to guide the public into making the wisest choice.

"In doing this, we must work together with the medical profession much more closely than we are doing today, stripping away areas of superficial conflict and clearly delineating what our respective functions and responsibilities shall be."

If Mr. Berke sees the future clearly, the public is going to ask hospitals to provide home care, social service, care of the mentally ill including alcoholics, and services for the aged and chronically ill, in addition to all the services that must be provided for the acutely ill and injured.

The whole population will have to help, through some insurance mechanism, with financing the provision of needed services for the aged, Tol Terrell, president, and Dr. Edwin L. Crosby, executive director of the

American Hospital Association, told the convention. Less than four million of 13 million Americans over age 65 are insured for hospital care today, Mr. Terrell pointed out. He and Dr. Crosby said the A.H.A. is convinced that younger age groups must carry some of the burden of financing care needed by these older people. Instead of rating hospitalization insurance premiums on the basis of individual group experience, as insurance companies commonly do, this requires "community rating" or a uniform premium level for everybody—as provided in the original Blue Cross concept—they said.

To accomplish this and other goals for a satisfactory nationwide health care prepayment program, consumer groups must be given a greater voice in the nonprofit health plans, Dr. Basil C. MacLean, president of the Blue Cross Association, told the convention. "The communities in which each plan operates will have to be brought into a closer partnership in setting Blue Cross policy and objectives," Dr. MacLean said. "Most Blue Cross boards have far too little representation of important consumer groups. Hospitals should not have more than one-third of the membership on Blue Cross governing boards. That would mean a more reasonable balance between buyers and sellers of our product and remove much of the suspicion that Blue Cross answers only to hospitals."

Removal of traditional hospital services such as radiology, pathology and anesthesia from Blue Cross contracts was described by Dr. MacLean as a "stumbling block" to the national effort to provide prepayment care.

"If we are to think of health service as a goal in a package sense, the hospital operation should not be as confusing to Joe Blow as the store where in buying a suit he had to pay for the coat in one place, the pants in another, the buttons in another. The next five years should see a far higher prevailing standard of benefits among the plans. I see that standard including provisions for preventive, diagnostic and rehabilitation services provided by hospital outpatient departments and benefits for long-term illness, convalescent care, home nursing, and the like."

Meanwhile, back at the hospital, administrators have a lot of cleaning up to do, Dr. Crosby told a press conference held in conjunction with the convention. To combat staphylococcal infections, hospitals may have to go back to the old floor scrubbing, wall washing, and terminal disinfection technics, he said.

The A.H.A. is helping out with this problem through its national com-

(*Continued on Page* 136)

Time and Distance Hurt Group Purchasing

Chicago.—Group purchasing generally doesn't work as well as it should, Sister Elise, treasurer-general of the Sisters of Charity, Cincinnati, declared at a purchasing workshop conducted at the Tri-State Hospital Assembly here last month.

"In pure theory, group purchasing should work perfectly," Sister Elise, who is a certified public accountant, told the group. "In actual practice, it has its disadvantages as well as its advantages."

The first disadvantage named by Sister Elise was the "slowness with which everything commonly is done" in group purchasing.

Reports on inventories or quantities wanted and the like must be forwarded by the branch division to the central office to be tabulated, compared and worked into large combined orders, she explained. "This at times results in the interrelated units being obliged to carry larger inventories than would be the case if these units acted individually, since each unit must have materials and supplies on hand to keep operations going while the central office makes up its mind about new contracts or changed ones," she said.

Another disadvantage is that the ultimate value of a particular product or brand may not be the same in one vicinity as in another, Sister Elise pointed out.

The problem of distance is a formidable one in a purchasing group, K. L. Kastner, director of purchases for St. Francis Hospital, LaCrosse, Wis., agreed. "One of our hospitals is approximately 300 miles away from the central office, and another is in Idaho," he explained. Eventually, he reported, the group had to give up purchasing for the Idaho unit.

Location is also important because of the need for firsthand contacts with administrators in group hospitals, Mr. Kastner added.

The solution to these difficulties is to grant a high degree of autonomy to the purchasing department or purchasing agent at each hospital unit, he said.

William E. Smith, executive director of the Hospital Industries Association, Chicago, told the workshop that, "in general, hospital purchasing is being handled intelligently and efficiently." However, Mr. Smith added, some hospitals still engage in poor purchasing practices, such as:

1. The administrator tries to handle purchasing details himself as a "sideline."
2. The purchasing agent is not included in the top administrative team.
3. Too little effort is made to simplify and standardize equipment and materials purchased by the hospital.
4. The hospital has no perpetual inventory system.
5. Too little time is spent studying new products.

New officers of the Association of Western Hospitals are, left to right: Paul S. Bliss, third vice president; Melvin C. Scheflin, executive secretary; Wesley G. Lamer, president-elect; J. L. Zem, treasurer, and R. J. Hromadka, president.

This description of a heart operation will help all concerned with patient care understand the problems and possibilities

Surgery may be a lifesaver in coronary heart disease

Herschel E. Mozen, M.D., and Claude S. Beck, M.D.

IT HAS been estimated that more than 1,000,000 new attacks of coronary artery occlusion, more than 300,000 of which are fatal, occur each year in the United States. In addition to killing hundreds of thousands of patients annually, coronary disease causes partial or complete incapacitation of hundreds of thousands of others who live in constant dread of the next attack of angina pectoris or of the fatal heart attack. While steady progress has been made in our ability to make a correct diagnosis, similar advances in the treatment of coronary disease have not occurred. Present-day medical therapy, consisting of rest, vasodilators and sedatives, and essentially no different from what it was 30 years ago, has done little or nothing to change the morbidity or mortality due to this disease. The ineffectiveness of medical therapy in the treatment of coronary disease should be a matter of concern to all physicians.

During the last 25 years, more than 6000 experimental operations have been performed on the hearts and coronary vessels of dogs in the Claude S. Beck Cardiovascular Surgery Research Laboratory. Principles have been established upon which the operation for coronary disease is based. These principles are derived from factual observations made during these experiments, and they have been applied in the treatment of more than 550 patients with coronary artery disease by surgical operation.

Between 80 and 90 per cent of patients with coronary disease die suddenly. These deaths are due to disruption of the normal cardiac mechanism, usually by the abrupt onset of ventricular fibrillation. This fatal arrhythmia often accompanies currents of oxygen differential which are set up within the heart, as a result of narrowing of the coronary arteries with an uneven distribution of blood flow. The presence of ischemic myocardium in contact with well oxygenated heart muscle renders the heart electrically unstable. In many cases of mechanism-death there is slight or moderate coronary arteriosclerosis and the heart may have little or no evidence of myocardial infarction. Often, it appears that these anatomically good hearts should be capable of continued function. In such cases, the protective coronary operation can be most beneficial.

SELECTING PATIENTS FOR SURGERY

In the past, emphasis has been placed upon attempts to add quantities of blood to the heart. These attempts have not been successful, consistently. Now, we recognize that an even distribution of the available coronary inflow is the most important factor in providing protection against electric instability of the heart and mechanism-death and against myocardial ischemia with infarction or angina pectoris. This even distribution can be provided best by stimulating the formation of an anastamotic network of intercoronary channels. These channels permit blood from well oxygenated areas of the heart to be diverted into ischemic zones. This is of vital importance at the crisis of coronary artery occlusion, when the fate of the patient depends upon the amount of blood which can be supplied through intercoronaries to ischemic myocardium beyond the occlusion (Fig. 1.).

Any patient with a definite diagnosis of coronary artery disease is a candidate for operation. Those with far advanced myocardial damage, cardiac enlargement, and heart failure are poor risks. The heart is electrically unstable for a period of six months following a myocardial infarction, and operation is hazardous during this interval. If there is a history of rapidly progressive angina, elevated sedimentation rate or serum transaminase, or suspicious electrocardiographic changes, operation should be delayed for six months. The patient then is reevaluated and frequently operation may be performed safely.

It is important that both patient and doctor be aware of the obvious limitations of operation. Improvement of symptoms and protection of the heart against the results of future coronary artery occlusion may be anticipated; miracles should not b expected. Surgical operation does n give the patient a new heart; it doe not remove preexisting myocardia scars; it does not alter the progression of the coronary atherosclerotic process; it does not guarantee that the patient will not die eventually from his disease.

The Beck I operation for coronary artery disease has four components, each of which contributes to the for-

From the department of surgery, Western Reserve University School of Medicine and the University Hospitals of Cleveland. Dr. Mozen recently was appointed director of cardiovascular research at Edgewater Hospital, Chicago.

mation of intercoronary anastomoses. The incision is made in the left, fifth, intercostal space and extends from the sternal border to the anterior axillary line. The serratus anterior and lattissimus dorsi muscles are undercut and elevated while the intercostal muscles are divided as far posteriorly as necessary. The lung is retracted and the pericardium is opened from apex to base, both in front of and behind the phrenic nerve. The posterior incision is extended as a "T" back to the coronary sinus.

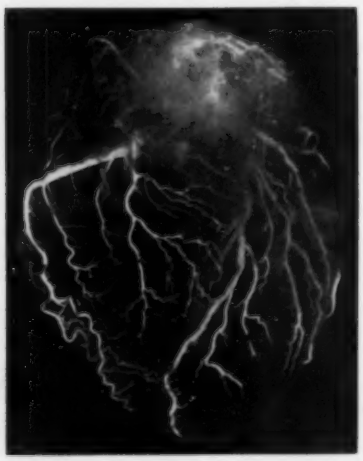
Step 1—Pericardial-Epicardial Abrasion (Fig. 2A). The entire lining of the pericardial sac as well as the epicardium is removed by mechanical abrasion with a surgical burr. Particular attention is paid to the posterior diaphragmatic surface and to the apex of the heart where intercoronaries form abundantly. Care must be taken to avoid rupturing the coronary vessels. If the heart is irritable, frequent rest periods may be necessary. Additional intravenous digitalis may be given during the operation to treat persistent tachycardia.

Step 2—Partial Ligation of the Coronary Sinus (Fig. 2B). The left ventricle is rotated forward slightly and the fat beneath the sinus is dissected free carefully and held downward with a traction suture. An atraumatic ligature needle is inserted directly into the right atrium below the sinus. The needle is turned 90° and brought out through the atrial wall, above the sinus. The ligature is tied tightly over a 3 mm. probe. When the probe is removed, there is venostasis but not complete obstruction of coronary sinus flow.

Step 3—Application of Inflammatory Agent (Fig. 2C). After pericardial-epicardial abrasion and partial ligation of the coronary sinus, the en-

DRAWINGS DEMONSTRATE MAJOR STEPS IN CORONARY HEART OPERATION

Fig. 1, below: Human heart many months after Beck I operation. The coronary arteries have been injected. Note the rich anastomatic network of intercoronary channels which can carry blood into areas of ischemic myocardium. The patient, completely incapacitated prior to operation, had returned to his full-time work.



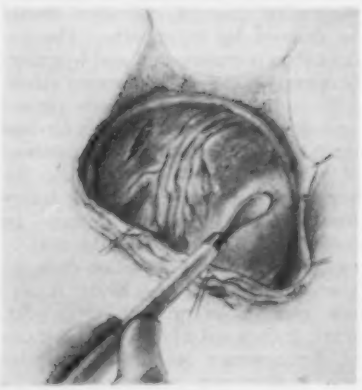
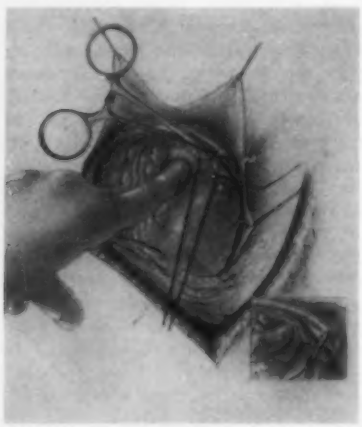


Fig. 2A, above: Pericardial-epicardial abrasion. Pericardial sac has already been abraded. Entire epicardium is removed by mechanical trauma with a burr. Inflammatory response to this trauma results in formation of intercoronary channels and vascular extracoronary adhesions.

Fig. 2B, below: Partial ligation of coronary sinus. The sinus is dissected free of surrounding fat which is retracted with sutures. The needle is inserted into the right atrium, just below and parallel to the sinus. It is then turned 90 degrees and brought out through the posterior wall of the atrium just above the sinus. The suture is tied snugly over a 3 mm. probe. This produces venostasis but not the complete obstruction of the venous flow.

Photographs here are reproduced with permission. Beck & Brofman: The Surgical Management of Coronary Artery Disease: Background, Rationale, Clinical Experiences, Ann. of Internal Medicine, 45:6 (Dec.) 1956.



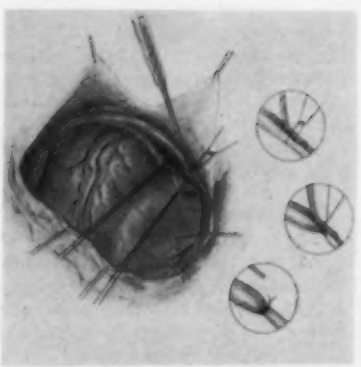
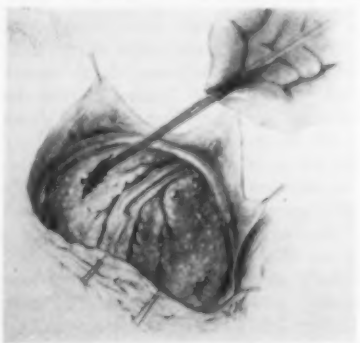


Fig. 2C, below: Application of inflammatory agent. The entire surface of the heart is coated lightly with 0.2 gm. of powdered asbestos. This material is a stimulus to the continued formation of intercoronary channels and vascular extracoronary adhesions.



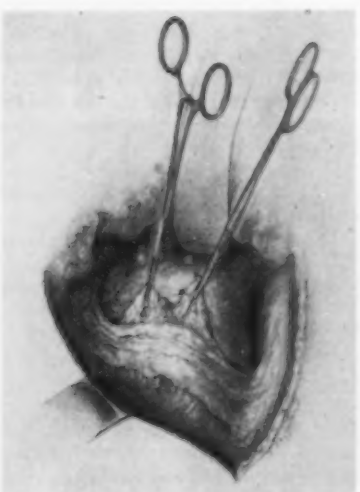


Fig. 2D, above: Application of fat grafts is shown in photograph. The pericardial sac is not closed tightly. The mediastinal fat pad is placed directly on the myocardium and sutured to the free edge of pericardium. Note how the vascular bridge containing the phrenic nerve and vessels is preserved carefully.

tire surface of the heart is coated lightly with 0.2 gm. of finely ground asbestos. This material has been studied and compared with many other substances and has been found to be the best stimulant for producing a mild inflammatory response with increase in intercoronary channels and extracoronary vascular adhesions. This inflammation has never resulted in chronic compression of the heart.

Step 4—Application of Fat Grafts (Fig. 2D). The mediastinal fat pad is dissected free. Care is taken to preserve its blood supply. This fat is then sutured beneath the edge of the pericardium so that it lies directly on abraded heart muscle. The pericardial sac is approximated very loosely over these vascular fat grafts so that fluid accumulation and cardiac compression cannot occur.

The chest wall is closed in layers with silk. A thoracic drainage tube is used for 36 to 48 hours.

ILLUSTRATIVE CASE

The following report is selected as a fairly typical example of a patient with severe disease. Operation was performed and results were excellent.

History: The patient was a 40 year old, white, male engineer who entered the University Hospitals of Cleveland on Nov. 15, 1955. He had a history of angina pectoris which began one year prior to admission. The pain was dull, substernal, oppressive and radiated up into both shoulders and to the jaw, and had become progressively more severe. For three months prior to admission, the patient had been completely incapacitated. He was using 5 to 10 nitroglycerine tablets and 3 to 4 ounces of whiskey per day.

Eight months prior to admission, the patient had suffered a massive posterior myocardial infarction. He was treated with bed rest and anticoagulants. He improved to the point of being able to get up in a chair for brief periods. Following his heart attack, the patient suffered three transient episodes of loss of consciousness.

Past history was unremarkable. There was questionable fatty food intolerance.

Physical Examination: The blood pressure was 123/70 mm. Hg.; pulse was 88 per minute; respirations were 20 per minute, and temperature was 37° C. The patient was anxious and talkative. He was well developed and muscular.

The lungs were clear to percussion and auscultation. The heart was of normal size with the apex in the midclavicular line in the fifth intercostal space. There was a regular sinus rhythm. Heart sounds were of poor quality. M_1 was equal to M_2 and A_2 was louder than P_2.

The remainder of the physical examination was unremarkable.

Laboratory Studies: The results of urinalysis, complete blood count, bleeding and clotting times, prothrombin time, and hematocrit were normal. The sedimentation rate was 3 mm. per hour; blood urea nitrogen —14 mgm. per cent; fasting blood sugar—78 mgm. per cent; serum proteins—6.5 grams per cent; serum chlorides — 105 m.e.q.; sodium — 141 m.e.q.; serum cholesterol—327 mgm. per cent; venous pressure was 7 cm. of saline; circulation time was 14 seconds; vital capacity—5.2 liters.

The x-rays of the upper gastrointestinal tract, gall bladder and colon were normal. Cardiac fluoroscopy and 4-projection chest films were obtained. The heart was of normal size. There was no specific chamber enlargement or abnormal cardiac pulsation.

The electrocardiogram revealed evidence of a remote posterior myocardial infarction.

Operation—Hospital Course: The patient was considered an acceptable candidate and a Beck I operation for coronary artery disease was performed on Nov. 21, 1955. The heart was of normal size; the myocardium contracted well. The common left coronary artery was soft and pulsated. Some branches of the descending coronary artery were thickened and streaked with atheromatous deposits. The terminal branches of the circumflex artery did not pulsate. There was a large posterior myo-

Preoperative Preparation of Patients Who Are Scheduled for the Coronary Heart Operation

These patients invariably are somewhat nervous and very concerned over their disease and their prognosis. Also, since a number of doctors still are not advising surgical operation for patients with coronary disease, many of the patients are a little doubtful about their operation. All personnel should make every effort to retain an optimistic attitude without losing the realistic point of view. The Beck operation for coronary disease is no miracle. Rather, it is a physiological attempt to improve the patient's chances over the years in the event of probable future coronary occlusions. Also, the operation will relieve myocardial ischemia and the pain of angina pectoris.

Most patients who enter the hospital for coronary surgery have had long courses of unsuccessful medical therapy and they are well acquainted with their disease and its many problems. They will ask highly controversial and technical questions. Nurses and other personnel should avoid any controversy by answering such questions in very broad general terms or by referring the patient to his attending surgeon.

These patients do not require elaborate preoperative workups. A careful history of the disease is most revealing. If the patient should experience unusual or prolonged anginal pain which is not promptly relieved by nitroglycerine, a new myocardial infarction should be suspected, and this should be reported to the attending doctor promptly. Incidentally, nitroglycerine should be allowed the patient as frequently as needed, provided he gets relief from it. Many patients fear that they will become addicted, but this fear is groundless and they should be encouraged to use this drug as often as necessary.

The usual preoperative EKG is obtained and compared with previous records. In addition, chest x-rays and fluoroscopy are obtained. Complete blood counts, blood chemistries, sedimentation rate, urinalyses, venous pressure, and circulation time are determined. If all is in order, operation can usually be scheduled within a few days after hospital admission.

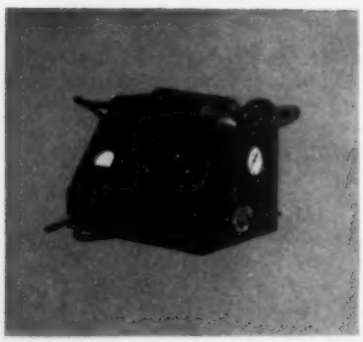
None of the preoperative evaluation of these patients requires any special or extraordinary equipment which is not usually found in any well equipped general hospital. The main difference between coronary patients and those who are being prepared for other kinds of surgery is that the coronary patients will tend to be more apprehensive and therefore will require more patience, tact and general understanding than most other patients. Beyond this, no special preoperative preparations are needed.

cardial infarct, which was 4 cm. in diameter.

The patient's postoperative course was uncomplicated. There was a slight febrile response following surgery, but his temperature was normal within four days. The thoracotomy tube was removed in 48 hours. Sutures were removed on the seventh day and the wound was well healed per primum. By the fifth postoperative day, the patient was able to walk several hundred feet without developing angina. He was unable to do this prior to operation. This early improvement continued and increased up to the date of discharge, 13 days after operation.

Late Results of Operation: The patient was reexamined 15 months postoperatively. There was no complaint of incisional pain. The pulmonary and cardiovascular systems were normal. The patient had returned to work three months after operation, and at the time of examination was working full time, without restriction. There had been an almost complete relief of anginal pain, and the patient was using no medications. Such improvements in symptoms and ability to work are definite and can be evaluated. Similar results have occurred in 90 per cent of patients who have undergone operation for coronary disease. It

EQUIPMENT, SUPPLIES AND OPERATING ROOM PERSONNEL NECESSARY FOR



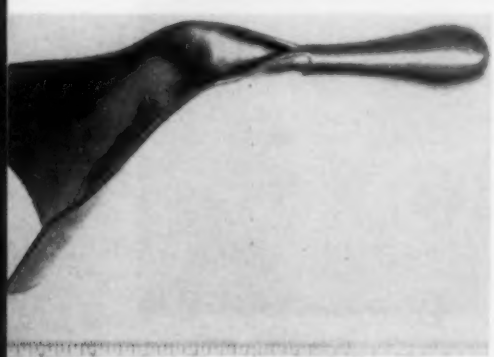


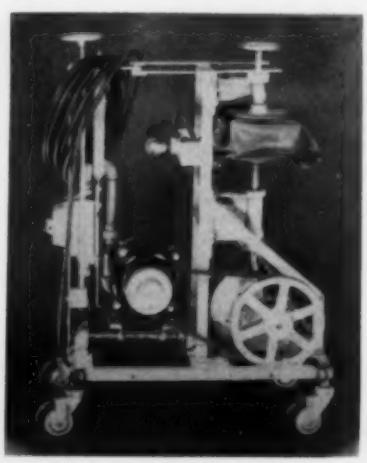
Fig. 3, left: With this easily portable defibrillator, which should be in every operating suite, fibrillation is converted to standstill and a sustained heartbeat then can be established with relative ease. The apparatus operates on 110 volts, A.C. Electrodes are removable for sterilization in an autoclave for 15 minutes at 250° F.

Fig. 4, left: Beck-Burke retractor, which provides excellent exposure of the heart with minimal compression of the lung, was specifically designed for use by surgeons during the Beck I operation for coronary artery disease.

Assuming that a careful preoperative evaluation has been done and the patient is determined to be a good candidate for surgery, the risk of operation should be very little and not greater than for any other major type of surgery. Naturally, the inherent risks of coronary disease per se must be explained to the family so that they understand the problems involved.

The most important equipment necessary for proper execution of the operation is a skilled and well trained surgeon who has broad experience in dealing with coronary disease. The anesthetist also must be gentle, skilled and in constant control of the patient so as to maintain good oxygenation at all times. On occasion, the patient will have a drop in blood pressure following the induction of anesthesia. In such an event, it is wise to cancel the surgery since it is evident that there is excessive myocardial destruction and operation would be too hazardous.

The usual number of surgeons is three: the operating surgeon, the first assistant, and the second assistant. Two nurses are needed, a scrub nurse and a circulating nurse. The sutures are standard, consisting of 3-0 and 4-0 silk, as well as #2 chromic catgut for pericostal sutures and heavy #0 Mersilene silk for the sinus stitch. The special instruments required are also simple and all can be easily obtained.



Figs. 5 and 6, right: A mechanical respirator, recommended in any case in which adequate pulmonary ventilation is required, is shown in two views. At the far right it is shown covered. The ventilation maintained by a mechanical respirator is similar to that which may be produced by manually exerting pressure on a breathing bag. The cycle of respiration is the same as that in normal deep breathing. Mechanical ventilation is more effective and frees the anesthesiologist's hands for other duties during the operation.

The cover of this month's magazine shows Dr. John W. Pender administering anesthetic at the Palo Alto Hospital.

seems certain that surgical operation, with its present low mortality, and its predictably high percentage of good or excellent results, will become increasingly important in the future treatment of coronary artery disease.

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THE EXECUTION OF THE CORONARY OPERATION

The instruments are:

1. Beck abraders: special tool steel burrs with which the lining of the pericardium and the epicardium are completely removed.

2. Beck-Burke retractor: a retractor which was especially designed for the coronary operation. It holds the lung back from the heart, without the necessity of opening the chest more than four inches. It has a smooth and glistening surface which prevents postoperative pleural adhesions.

3. Beck measuring probe: a special probe of steel which is exactly 3 mm. in diameter. When the coronary sinus is tied down over this probe, its lumen is reduced to this size, which causes venostasis but not venous occlusion.

Since occasionally ventricular fibrillation or asystole may occur, the entire setup for cardiac resuscitation must be available, including the defibrillator. These have been described in detail in a previous publication.*

The operation usually takes less than one hour, unless unusual circumstances occur. At the end of the operation, as the chest is being closed, a large catheter is placed into the pleural cavity to allow any blood or serum to escape and thus eliminate the need for postoperative thoracenteses. Also, 1,000,000 units of crystalline penicillin and 1 gram of streptomycin in a total of 30 cc. of saline are instilled into the pleural space prior to closure.

The patient is taken to the recovery room for careful observation following operation. He is watched until he is fully conscious and until the pulse and blood pressure are completely stable.

It should be noted that the patient must be carefully monitored by electrocardiogram and oscilloscope apparatus throughout the entire procedure. In this way, slight changes in myocardial oxygenation and irritability may be detected promptly and corrective measures applied. There are a number of devices available for this purpose and they vary widely in their complexity and cost.

*Mozen, Herschel E., and Beck, Claude S.: Are You Ready to Treat Cardiac Arrest? Mod. Hosp. 89:51 (November) 1957.

DRUGS ON CARDIAC RESUSCITATION TRAY

1. Adrenalin (epinephrine) solution, 1:1000, 1 doz. 1 cc. ampules
2. Procaine hydrochloride solution, 1 30 cc. vial (1 per cent)
3. Cedalanid (lanatoside C, intravenous rapid acting digitalis preparation) 1 doz. 2 cc. ampules
4. Pronestyl (procaine amide solution) 2 10 cc. vials
5. Atropine sulfate solution, 1 25 cc. ampule
6. Hydrocortisone, 3 100 mgm. ampules
7. Quinidine sulfate solution, 1 10 cc. ampule
8. Ephedrine sulfate solution, 6 2 cc. ampules
9. Neosynephrine solution, 1 10 cc. vial
10. Levophed (norepinephrine) 6 4 cc. ampules
11. Wyamine, 1 30 cc. vial
12. Molar lactate solution, 2 100 cc. ampules
13. Insulin, U40, 1 10 cc. vial
14. 50 per cent glucose solution, 2 100 cc. vials
15. 6 each of 5 cc., 10 cc., 25 cc. syringes; 2 50 cc. syringes
16. 6 each of 2 inch No. 16, No. 18, No. 20, No. 22 needles. 6½ inch No. 24 and No. 26 needles
17. Tourniquets

Postoperative Care of the Coronary Patient

The care of the patient after a coronary operation is the same as for any patient after a major thoracic procedure. Skillful, thoughtful and efficient nursing care is the single most important factor in a smooth and uncomplicated convalescence.

The blood pressure should be observed carefully and if persistent hypotension occurs, vasopressors may be needed. Irregularities of the pulse should be reported promptly and checked by EKG. There will be considerable chest wall pain after operation, and sufficient narcotic should be given to relieve this without causing the patient to become sleepy. The retention of bronchial secretions is a serious problem and these patients must be urged to cough frequently in order to expel these secretions. Deep breathing is also a must in order to expand the lungs fully. The chest drainage tube will permit any accumulation of pleural fluid to drain out and the doctor will remove it after two to three days. The sutures are removed in seven days.

The patient is encouraged to begin early ambulation. He is assisted to sit up and dangle his feet over the side of the bed on the night of surgery and is up in a chair and walking the day after. Diet and fluids are advanced as tolerated and the bowel movements are kept regular.

The postoperative course is usually uncomplicated and the patient does not present any special problems. The question of private nurses deserves consideration. If good, alert and competent nurses are available and the family wants them, they are desirable for the first three to four days after surgery. In many cases, however, where special care units are available, one nurse may adequately supervise a number of critically ill patients with several nonprofessional assistants. Incidentally, these patients are always placed on the hospital's critical list for a period of one week after surgery.

Most patients are ready to leave the hospital in 10 days or two weeks. The first postoperative visit is in six weeks, the second in three months. Most patients are ready to return to full-time work three or four months after surgery.

Features of an Efficient Nurses' Station

Following is a summary of some of the features we have found to be desirable in the planning of an efficient nursing station (although we are sure there are many others we perhaps have overlooked):

1. ***Location***
   —If possible, the unit should be located at the center of a nursing division. (At the vertex of of a V-shaped division or at the point where the two corridors meet in a T-shaped division.)
   —Where practical, the unit should be close to the elevator landing.
   —It should be reasonably near nursing utility areas.
   —It should be in an area with some elbow room, not too crowded by corridor traffic.

2. ***Size***
   —A study should be made of the number of persons who have reason to use these facilities, and the nature of their duties. The size varies, of course, with the type of hospital, but might normally include: a charting area for two nurses to work simultaneously; space for a ward clerk and/or volunteer; a space for medical charting and the writing of doctors' orders, and a place for members of the dietary staff and students. An area for consultation in, or near, the station is also desirable.

3. ***Lighting***
   —All working areas should be amply lighted, with adequate controls to reduce the lighting during night shifts.

4. ***Acoustical Treatment***
   —A relatively low acoustically treated ceiling baffle is extremely desirable.

5. ***Enclosure Versus Open Area***
   —It is our opinion that an area with ready access is infinitely better than a closed room or the glassed-in nursing stations of earlier years.

6. ***Position of Counters***
   —One section might have a 30 inch high counter area for persons (such as ward clerks) whose duties would not take them from the desk too frequently, but all other areas should have counters 42 inches high. The charting area should be wide enough to permit working from each side (as in Figures 3, 4 and 5).

7. ***Construction Materials***
   —We have used cast stone around our units, but any hard-surfaced material may be used that will stand the normal abuse that a dado area oftentimes receives.

8. ***Chart Racks***
   —The circular type (as shown in Figures 4 and 5) has proved the most satisfactory.

9. ***Special Equipment***
   —Definite locations for the pneumatic tube outlet or other unusual installations should be incorporated as appropriate.

Clarence Wonnacott

New Station

DOCTORS and nurses stepping all over each other in the attempt to get their respective jobs done.

This was the situation in our nursing stations a few years ago which prompted a plea from one of our head nurses: "Can you help us find a way to keep the doctors off our laps?"

Facetious, to be sure—but it clearly pointed up the frustrations all of our nurses faced in trying to perform their duties in nursing stations that were anything but functional.

Probably our hospital was no different from many others that use the traditional charting desk, which makes it necessary for doctors to reach over the heads and shoulders of nurses to get at charts. Even worse, from the standpoint of inconvenience to nurses, was the fact that a doctor would commandeer a nurse's chair each time her back was turned in order to use her desk for his medical record entries.

We would be less than frank if we did not admit that our early efforts toward solution of this difficult problem really went through a trial and error period before we arrived at a workable arrangement.

As a matter of fact, our first two attempts at modernizing and functionalizing our nursing stations still left us with a lot of inadequacies.

To start with, we had two types of nursing stations: the "open room" type illustrated in Figure 1, and the glass enclosed "sentry post" type shown in Figure 2. We attacked the "open room" type first. We retained the old desk-style nursing chart units, but installed desk-height counters around the room which could be used with castor equipped stools.

Although this gave the doctors a place to do their charting, it still presented a problem of having the working areas somewhat removed from the chart holders themselves. And it still provided no guarantee against a doctor's taking over a nurse's chair.

Our next attempt was a more radical departure, as shown in Figure 3. Here a counter has been installed with wells at either end to accommodate the charts. The nurses work from the

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It took several attempts but finally a nurses' station was designed that eliminates confusion and keeps doctors and nurses at work and at peace

Makes Nurses' Work Easier

Fig. 1, above: One of two original types of nursing stations; desk-height counters were installed, but charts were too far away from working area, and doctors still took nurses' chairs.

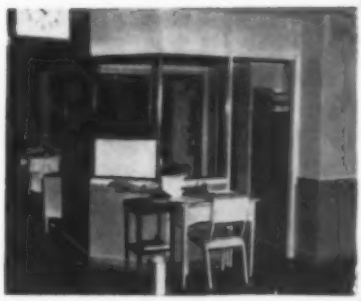

Fig. 2, above: Glass enclosed type of "sentry" station also was used originally. After several tries at remodeling open-room stations, a solution was found for sentry type. (See Figs. 4, 5.)

Fig. 3, above: The design chosen for open-room stations. Counter stools did keep doctors out of station, but the well type of chart holder at each end of the counter proved somewhat inconvenient.

Fig. 4, above: The most successful solution was that selected for the former "sentry" nursing stations. One end of station accommodates ward clerk and volunteer in area near the elevator. This is good because they can give information easily and are near the intercommunications system and can do much of the paper work. Charts are kept in a circular chart holder, a type strongly recommended for its speed, convenience and versatility. Doctors sit on chairs outside the station, but can work well at counter.

Fig. 5, above: Space in foreground of remodeled station is available for dietitians, students or others working with nurse. New station aids record keeping.

inside area, while the doctors work from the corridor side. This at least kept the doctors out of the nurses' working area, avoiding that inconvenience, but it left something to be desired in other respects.

For instance, the well type of chart holder at either end of the counter proved inconvenient to some degree because the charts were not as accessible as we wished them to be. Some architects have used a chart-well down the center of the counter with certain success. However, our strong recommendation is for a different type, which will be described.

Armed with the knowledge we gained through revisions of the "open room" nursing stations, we finally settled upon a new approach for remodeling the "sentry post" stations. The results are shown in Figures 4 and 5.

One end of the station accommodates the ward clerk and volunteer in close proximity to the elevator (note in Figure 4). This, we feel, is desirable because it places them in a convenient location to give information, and they have ready access to the patient-nurse intercommunications system and are able to do much of the paper work on the division.

Occupying the center area of the station is the charting counter with two high-back stools on each side—the inner side being for the nurses, and the corridor side for the doctors. Notice, too, that in the center of the counter is a circular chart holder. This is the type we strongly recommend because of its speed, convenience and versatility. (Incidentally, a great improvement has been noted in the manner in which our doctors keep continuing progress notes and other information recorded on the chart.)

The other end of the nursing station (shown in foreground of Figure 5) is available for dietitians, student nurses, or other personnel working closely with the charge nurse.

Our experience with this nursing station proved so satisfactory that we have since converted five other units into this design. Both doctors and nurses feel this working area is considerably more conducive to the accomplishment of their tasks. #

85 Bed Hospital Is Equal to 400 Victims

It was hard on the members of the Sunshine Society, but the outbreak of food poisoning that inundated this hospital with 400 victims had the desirable effect of serving as a proving ground for the disaster program and arousing the community to the importance of the program

Ralph M. Haas

CRAWFORDSVILLE, the Athens of Indiana, is a typical, quiet county-seat town of 14,000, much like dozens of other rural towns in the Hoosier state. It is noted chiefly for its authors, artists, conservatism, Wabash College, the printing industry, and Hoosier hospitality. One additional claim to fame stems from the fact that Crawfordsville is the birthplace of the Sunshine Society, a statewide charitable organization made up of girls of high school age.

Saturday, April 19, was much like any other Saturday at Culver Hospital. The 85 bed county hospital had only 86 patients which, in these days of overcrowding, was below par. Spring fever had invaded the administrator's blood and he had left the hospital, dedicated to the task of removing the storm windows at his home.

The only unusual event of the day was the annual state convention of the Sunshine Society at the local high school. A preregistration count promised that there would be in excess of 2300 teen-aged girls in attendance. This event held little promise for changing the routine hospital day unless some unfortunate participant in the festivities should fall down the auditorium steps or catch her finger in a car door. In short, Crawfordsville and Culver Hospital were enjoying a beautiful spring day.

The switchboard operator at Culver Hospital, beset by boredom and quiet, was reading the afternoon paper which carried the prophetic headline: "Teens in Spotlight Here Today." She was roused from her lethargy by all three trunk lines on the switchboard coming to life at one time. The first call was from a hysterical woman proclaiming, "Send a doctor quick, there are five girls dying in my front yard!" The caller hung up without giving either her name or address.

The second trunk line came forth witht the same message, involving four girls, this time with both name and address. The third call came from a service station operator who was the involuntary host to a bus loaded with 28 girls, all violently ill. After 30 minutes the switchboard continued to receive identical messages, with variation only in the point of location. Within 20 minutes the hospital had received more than 100 girls, all with the same complaint of violent nausea with projectile vomiting. The vehicles arriving with the patients were a sight to see. Most of the girls were unable to stand or sit and were on the floors of the cars and buses covered with vomitus.

With all the cots, beds and corridors filled to capacity at the hospital, the high school gymnasium was designated as an emergency hospital and the loads of patients rerouted to that location. The hospital nursing staff was divided into two groups, as was the medical staff, and teams of each were taken to the gymnasium to care for the sick at that location. The influx of patients lasted for slightly more than 90 minutes. In that period a total of approximately 400 victims were housed in one way or another. Many of the school buses carrying their girl passengers had departed early enough to come within range of surrounding hospitals before the illness struck. Townspeople, finding the victims lying on lawns and sidewalks, took the girls into their own homes; some had as many as 12.

As the magnitude of the disaster became evident, an emergency call was placed to the Red Cross in Indianapolis for a shipment of 100 cots; it was more obvious by the minute that the existing facilities were completely inadequate to care for the number of patients. We knew that there had been 2300 registrants at the convention and, as the patient load increased, we feared that all were ill. We did not learn until later that only 800 of the total number had been served at the school cafeteria where the tainted food had originated.

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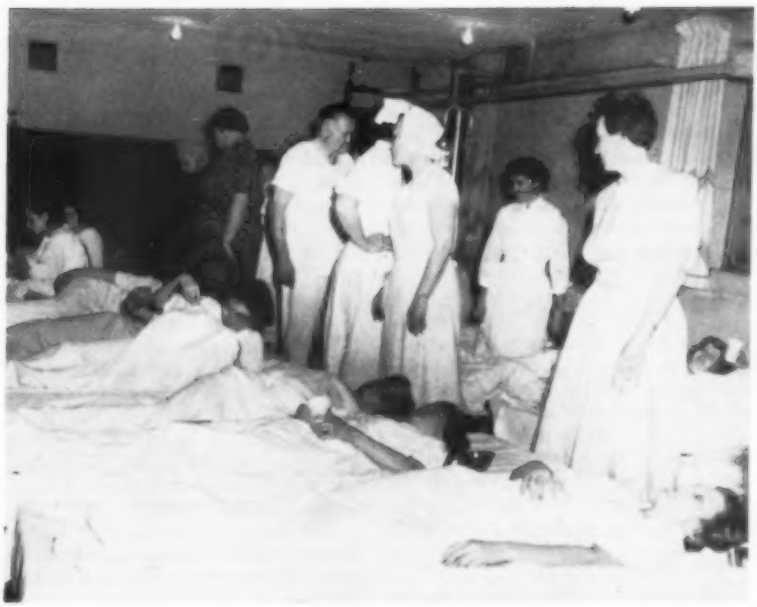

Left: Patients were taken to basement of nurses' residence when cots arrived from Red Cross. Moving 46 girls took less than one hour. Patients were carried on stretchers or cots or moved in wheel chairs. Volunteer workers from civic organizations and service clubs aided hospital personnel in transferring the teen-agers to this room. Approximately 400 girls were cared for in the nurses' residence or school.

Above: By Sunday morning, many of the girls were ready to leave for home with their parents, who came for them.

Above: Neighbors kept track of the whereabouts of every girl so that parents could be directed to the right area.

In one of the first busloads of patients we found a paper bag containing two ham salad sandwiches. Since these were the major items of the sack lunch they were immediately given to our pathologist, Dr. Wemple Dodds, for appropriate testing so that we might know just what organism we were fighting.

Months previously the hospital and medical staffs had joined in formulating a disaster plan of operation. This plan was put into force and proved to be most satisfactory. It was necessary to modify the plan only to suit the particular disaster for it was written with the thought of a disaster arising from a tornado or enemy action and included screening centers that were totally unnecessary in the immediate disaster. The administrator, as a co-chairman of the Red Cross disaster committee, was in a position to augment the regular hospital staff with Red Cross and Civil Defense personnel. The disaster plan, being simple and concise, proved to fulfill all the hopes that had been held for it.

At the time of admission to the hospital no attempt was made to register or classify the girls. Most of them were so extremely nauseated or in such a state of shock that nothing could have been gained by adding the rigors of questioning to their discomfort. Each girl was placed in a bed or cot or on a pallet on the floor until a more permanent and comfortable disposition could be made of her. She was tagged with a tag showing only the medication given and the time, the medication being identical in more than 90 per cent of the cases. Parenteral dimenhydrinate was given initially to all patients and, in a few cases, morphine was also used. In an additional 10 cases intravenous fluids were given for shock. Almost without exception the illness followed the same course: sudden projectile vomiting and retching at the onset, followed by a stuporous period of approximately 30 minutes which was in turn followed by violent diarrhea and cramping. The cramping was not confined to the abdominal area but also involved the extremities. During this period the victims were given paregoric and bismuth. The most acute portion of the attacks covered a period of from two to three hours.

The three-hour period was adequate time for the Red Cross cots to arrive, which brought some organization to the chaos. In 1951 a nurses' residence was constructed directly across the street from the hospital. It was built primarily for staff housing but was constructed so that it could be converted to an emergency hospital in a very short time. We felt that an emergency had arisen.

Within an hour after the first warning of the disaster, the basement of the nurses' residence had been cleared for action. Furniture had been removed and adequate supplies of drugs and linens moved in to care for 50 patients. Everything was in readiness when the cots arrived; they were set up immediately and the process of moving the patients started.

With the moving of the patients came the registration. Their names and home addresses were added to their tags. A list of the names and addresses was prepared and photostatic copies made to be sent to the gymnasium so that all the victims could be identified. In turn, the names of the patients at the gymnasium were listed and sent to the hospital for photostating so that each of the two units would know the names of the occupants of the other. Within an hour and a half after admission of the first patients the hospital had complete lists of names of all the victims to give to the press.

Accompanying each group of girls from the various schools throughout the state was a sponsor, in most cases a teacher. Fortunately, the sponsors had eaten at locations other than the school cafeteria and were able to be of invaluable assistance in comforting the girls. The sponsors were also able to place long distance calls to their home schools to reassure parents of the victims. They were

asked to advise the parents not to come to Crawfordsville until the following morning, for it was felt that the girls should not be transported home before that time.

The removal of the patients from the hospital to the nurses' residence was effected through the aid of volunteer workers from civic organizations and service clubs as well as regular hospital personnel. The patients were carried on stretchers and cots, and a few who had recovered sufficiently were transported in wheel chairs. Forty-six girls were moved into the basement of the nurses' residence with the entire operation taking less than one hour.

The girls who were not stricken were sent to the local movie, since the illness of their friends was not a pleasant sight. Civilian defense police were stationed at the doors of the hospital and told to keep out everyone not having good cause to enter. They performed their job quite effectively. Visiting hours at the hospital were canceled to cut down on unnecessary traffic within the building even though none of the poisoning victims were placed on the floors housing the regular patients.

At the onset of the disaster all off-duty members of the hospital and medical staff began appearing of their own accord. Only a few key employes were called. Help was not at a premium; in fact, it was so plentiful that several nurses were asked to go home so that they could report at midnight, and we would not be caught with the entire staff worn out at one time.

As the girls were carried into the nurses' residence they were registered, their remaining clothing was removed, and they were dressed in hospital gowns. Each cot was equipped with a sheet, pillow and bath blanket. The single cotton blanket was adequate in most cases; however, in some instances woolen blankets also were used where desired. When each patient was disrobed, her clothing, shoes, purse and other belongings were placed in a large one-half bushel, No. 60 paper sack[1] and marked with her name. Each sack was stapled shut and placed under the cot. These sacks had been purchased some months previously and placed in the hospital disaster equipment stockpile. They are of such a size that even hoop skirts, of which there were many, could be placed within them. Their value is evidenced in the fact that after all the excitement had ended and the girls were dismissed and returned to their homes, the one lost item was a single strand of beads.

By midnight some of the girls who were less ill than most were released to go home with their parents, who came from all parts of the state. Those remaining were asleep by midnight.

With the morning came the clean-up operation at the hospital. The entrances, corridors and articles of equipment were a sorry sight. Upon their arrival the girls were covered with vomitus and the general contamination was multiplied greatly after their admission. The corridors and walls showed graphic evidence of the extent of their illness. Thirty volunteers reported at 8 a.m. to participate in the mop brigade. It would seem that this is perhaps the most difficult of all disaster duties to accomplish. The glamour of the disaster is gone and with it the excitement; nothing is left but manual labor and those who volunteer for that detail are the dearest to the administrator's heart.

CLEAN-UP PROCEDURE

All furniture on the first and fourth floors of the hospital, where the patients were housed originally, was taken out of doors. Each piece was scrubbed with water and detergent, then sprayed with a 1/500 solution of benzalkonium chloride. After it had stood 30 minutes it was wiped dry and lined up for replacement in the hospital. The corridors, walls and windows received the same cleaning treatment as the furniture. By noon on Sunday the cleaning operation had ended, the furniture replaced, and the hospital was again ready for business as usual—with one exception.

During the excitement of the previous evening a hasty conference involving the pathologist, members of the surgical staff, and administrator had been called. The pathologist reported that the offending organism was unquestionably hemolytic Staphylococcus aureus, not, however, of a particularly virulent strain. (Subsequent cultures and animal injections have proved the diagnosis to be correct.) It was decided at the conference to quarantine the surgery for four days except for extreme emergencies. This action was deemed advisable because of the rash of hospital staphylococcic infections reported in recent hospital and medical literature.

The victims, having spent a quiet and restful night, were in good spirits though they appeared to be something less than "Sunshiny." Their parents called for them Sunday after they had been dismissed by the physicians. At 3:30 p.m., 24 hours after the first warning of disaster, the last girl left the nurses' residence for home.

The hospital waived all charges for treatment of the girls.

The score for the disaster appeared thus: food poisoning from ham salad contaminated with hemolytic Staphylococcus aureus; approximately 500 casualties suffering from projectile vomiting, diarrhea and shock. Treatment: Dimenhydrinate, paregoric, bismuth and bed rest. Fatalities: none. Experience for hospital personnel: much.

Ours was an easy disaster. No diagnostic problem was involved, for all the victims were suffering from the same illness. There was no screening problem to be met except the degree of illness, which varied but little.

The cooperation and coordination of the Red Cross and Civil Defense personnel with the medical and hospital staff were excellent. The result was the ultimate in community unity. The physician, the nurse, the farmer, and the mechanic each worked hand-in-hand toward one goal.

The board of trustees of Culver Hospital felt it desirable to send the administrator to the course in "Management of Mass Casualties" at Walter Reed Army Hospital, Washington, D.C., last month. It is hoped that his effort in this disaster justified their interest in disaster planning.

Press, radio and television personnel gave their complete cooperation. They were advised to remain outside the hospital area until the situation had been brought under control; then they would be allowed free rein to proceed with their respective duties in covering the disaster. They lived up to their part of the bargain and at the designated time proceeded with their work with no confusion.

The stockpiling of paper bags for storing patients' belongings may not be original but we know of no other specific system using this method. It is cheap and compact and offers a very satisfactory solution to one of the problems in handling mass casualties.

The tags for identification were those developed by Robert Jones of Waukesha Memorial Hospital, Waukesha, Wis., after the disaster there in 1954.[2] They proved most satistory. The method of affixing tags to patients, whether by pins or strings, still leaves something to be desired.

Of course, no one anticipates a disaster with relish; however, it does present a proving ground for ideas and implementation that could not be tested fully in a dry-run disaster practice. Neither does the mock disaster practice bring out the esprit de corps in the hospital staff, medical staff, and the community that is so important when a real disaster strikes.

At best, having a disaster dropped in your lap is a poor way to spend a spring afternoon in Indiana. #

[1]Manufactured by Martin-Brower Paper Co., 1727 South Stewart Avenue, Chicago 16.

[2]Staff Responds Promptly in Waukesha Hospital Emergency. Mod. Hosp. 86:68 (June) 1956.

Who's Accountable for Accounts Receivable?

The financial and mechanical phases of a hospital's operation are the business of the accounting office, but the social and human aspects are the business of every member of the hospital staff

Edward H. Heyd

ONE of the standard and highly regarded hospital accounting manuals defines accounts receivable: "This account is known as a controlling account; its balance represents the total of the balances due from hospital patients as shown by their individual ledger accounts."

The accounting approach to accounts receivable is essentially one of mechanics, yet the social and human aspects of this phase of hospital operation are even more important. Accounts receivable represent numerous transactions involving the interplay of various people—from the time a patient enters the door until a documented ledger in the business office concludes the hospital stay, as often as not, with a balance due entry. Thus the accounts receivable in a hospital represent more than a mere record of the balance due from patients. The character of the institution—the thoughts and acts of its employes—cannot help but rub off on the paper work in the business office. The clerks in the business office are just as much a part of the character of the hospital as members of the nursing or medical staff, or any other employe. The declared purposes of the hospital, its organizational plan, the physical layout and décor, and the desire of the hospital personnel to do a job all affect the institution's personality, and all these factors also influence accounts receivable. These are some of the conditions that constitute the hospital environment; they have a bearing on the quality of the hospital and are reflected also in a measurable quantitative factor – the total of monies due in accounts receivable.

Of course, the hospital's character is not created overnight. Institutions which have established a reputation and are known as good hospitals—"well managed"—are likely to have a good record of accounts receivable. The proper collection of monies due is an important part of the over-all hospital operation—particularly so now that receivables generally are reported to be on the increase. The hospital must take steps to see that it receives its full share of consideration when patients face their outstanding obligations.

A hospital may be schizophrenic—that is, the accounts receivable may be split from the rest of the hospital's activities and treated separately. What is to prevent the philosophy of accounts receivable from clashing with the ideals which are vigorously preached by the nursing department? How is nursing care interpreted in the business office? Does nursing have one standard and the business office another? A divided hospital personality is no healthier than a split human personality. Accounts receivable are a part of the whole. They have to be incorporated in the planning, the thinking, and the acting of the whole hospital.

Too frequently the stated purpose of a hospital has no relationship or bearing on day-to-day business activities and, especially, the handling of accounts receivable. It is a lofty and well meaning statement, usually prepared by dedicated people who have founded the hospital, or who are charged with its operation. But, unfortunately, it is probably unknown to the employe on the firing line charged with operating responsibilities. Obviously the handling of accounts receivable has a definite relationship to the stated purpose of the hospital. It is the responsibility of management to integrate and interpret the policy to assure appropriate execution.

For example, hospital annual reports and information booklets commonly reveal idealistic statements along the following lines: "No person shall be excluded from the service of the hospital because of race, creed, color, or ability to pay." Or, one may find statements similar to the following: "The object of this corporation is to maintain and operate an institution for the treatment of sick people under the direction and supervision of skilled physicians and surgeons."

To operate a hospital under a literal interpretation of the first statement would require considerable financial backing. Implementation of the policy would be truly an accounts

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receivable section's dream. There would be no problems. Funds would be provided by an endowment, the community, the government, or some other source which would enable the hospital to serve its patients "regardless of ability to pay." Unfortunately, this dream seldom comes true. In practice, there are usually many qualifying factors requiring a limiting interpretation of the stated policy to meet the local situation and the general lack of funds. The content of the stated purpose and its interpretation have a definite relationship to the over-all operation of the hospital and are reflected subsequently in accounts receivable.

Consider the second statement. There are various interpretations, even within the board, at the level where policy supposedly is formulated. Some trustees think the hospital cannot afford any free patients; too many people say they cannot pay. Everyone has to pay in order to maintain solvency, these trustees insist. Others reply, "The poor people just cannot pay for these expensive illnesses." There is nothing in the stated purpose of the hospital which says there shall be no free patients, nor does it say that some people must be treated as medically indigent. In the absence of a definite statement, it is usually management's responsibility to determine the intent of the declared purpose and to translate the purpose in such terms that all the employes who have anything to do with patients' finances will have a common understanding of what should be done.

It is apparent from these two examples that the over-all purpose of the hospital has to be reviewed and interpreted in the light of current needs and local practices, and that a translation in understandable terms has to be provided for the people who are responsible for actually doing the job. A high-sounding policy, vague and unrealistic though it may be, provides an apparently simple approach to collecting money from sick people. Without specific, understandable directions, even the best meaning employe may be guilty of prejudice and unimaginative interpretation at the operating level. This is not conducive to a healthy hospital; it breeds misunderstanding and distrust. Lack of consistency in understanding policy and making decisions leads to dissatisfaction and confusion, not only among hospital personnel but, unfortunately, among the people it is our job to serve.

START AT THE FRONT DOOR

Accounts receivable start at the front door, where hospitals have no choice of acceptance or rejection, and end in an account file. This is never a one-man job; the full effectiveness of all personnel is required to maintain a satisfactory accounts receivable balance.

What part do the physical layout and décor play in accounts receivable? How does the physical environment enter into the ease with which balances due are kept to a minimum? Perhaps the following questions will assist in developing a train of thought:

1. Do we make it easy for the patient to be admitted to the hospital? What part do the following play: reception desk? preadmission? directional signs? physician's instructions?
2. Is the admitting office conveniently located near an entrance to the hospital?
3. How do we welcome the patient entering the hospital?
4. Is the admitting office comfortable for the patient? efficient for employes?
5. Is the office appropriately furnished—a sufficient number of straight-back chairs; small, uncluttered desk; absence of office equipment such as typewriter?
6. Is the waiting room appropriately furnished?
7. Do office and waiting room give the appearance of austerity or of luxury?
8. Does the admitting office provide privacy?
9. Does it encourage full cooperation of the patient and put the patient at ease?
10. Is the patient given the impression that he is the *only* concern of the admitting clerk at this time?
11. Is the patient called by name during admission?
12. Do we make it easy for the patient to pay his bill? Is the cashier's office easily accessible? Is it open

How Business Office Affects Receivables

HERE are some questions about business office organization and function that will affect experience with accounts receivable:

1. Is it a cohesive organization that pulls together—with the same ideas and understanding of purpose?
2. Does it follow the conventional, straight-line organizational pattern in presenting definite duties, responsibilities and authority?
3. What are the variations from straight-line organization?
4. Does the organizational plan satisfy the needs of the organization?
5. How are responsibility and authority defined and delegated?
6. Is there good communication all along the line?
7. What is the over-all function of the business office in the hospital?
8. How is the business office related to the rest of the hospital?
9. How are specific functions aligned within the business office—*i.e.* accounts payable, accounts receivable, credit, collections, payroll, admitting, general ledger, statistics?
10. Are specific business office functions clearly defined and understood by all concerned?
11. Is someone responsible for coordinating the various functions? For training personnel? For improving methods?
12. What is the basic philosophy of the admitting office?
13. Who has the responsibility to assign rooms? By what authority?
14. Is the patient's financial condition the only basis for determining a room assignment?
15. What part does the patient's condition play? Who evaluates the patient's condition?
16. How are reservations handled? Is it a first-come, first-served basis?
17. Who has authority for initiating a transfer? If approval is required, who approves transfers?
18. Who has final decision to transfer a sick patient?
19. What is the basic philosophy for determining credit?
20. Who is responsible for determining credit?
21. How is credit determined?
22. Are there controls for limiting authority in extending credit?
23. When is a special decision required in extending credit?
24. What is the basic philosophy for collections?
25. Who is responsible for collections?
26. Are accounts aged?
27. What are the specific controls for collections?
28. How far can a collection problem go before meriting special handling?
29. Who is responsible for follow-up of accounts—*i.e.* patient in hospital, discharged patient, outpatient?

for business at convenient hours? Are invoices understandable?

13. Do we make it easy for the patient to discuss his bill?

The big question is: How much have we considered the needs of the average patient coming to the hospital with great apprehension and fear, accompanied by some member of the family or friends who are equally scared? Have we reassured these people that they are in good hands, and at the same time made it possible for us to develop a financial understanding without giving the impression that we have no thought for their trouble but only want to be sure we are paid?

The most ideally stated purpose translated so everybody can understand its application, the most efficient organizational plan, and the most effective physical layout and décor are of no avail if the employes are not instilled with the desire to use all the tools and advantages provided them to do the job.

The employe who really wants to do his job is obvious to all. He will stand out by his contribution to the over-all effect. An employe in any phase of accounts receivable has to approach his job with a positive and understanding attitude. He must realize his job is just as important and just as necessary to the successful operation of the institution as are those of other members of the team. He must realize also that his contribution is just as significant as others' in sponsoring an attitude of good patient care.

Intelligent supervision, constant training, and frequent adjustments are required to maintain this desired level of achievement and the proper balance of effort on the part of all the employes.

This concept includes all members of the hospital team. While it is the specific duty of only a few clerks in accounts receivable to collect money due the hospital from patients, it is the responsibility of every employe to contribute to this goal. Dissatisfaction with a cold meal, discourtesy by an aide, even a dirty room, are all causes for patients to develop real or imaginary reasons for not paying their bills. The task of collecting money is no more a one-man job than is nursing, the clinical laboratory, or the x-ray department.

While the entire hospital staff thus contributes something to the over-all experience with accounts receivable, the specific procedures in admitting, billing and collecting must be soundly established and properly executed so that the work of others may produce the desired result. It is the responsibility of the admitting office

These Are Duties of the Business Office

THE **admitting office** institutes procedures to have all accounts receivable under constant supervision and prompt follow-up. The most expeditious means of communication—personal visitation, telephone, statements, letters—should be used. The duties specifically include:

The **admitting officer** supervises and approves the credit evaluations determined by the admitting clerks. He reviews and reclassifies accounts as "secured" or "unsecured" on the discharge of the patients.

All accounts are then further broken down and processed in one of these categories: welfare, workmen's compensation, Blue Cross, wage assignment, credit status.

The **admitting clerks** negotiate, at time of admitting the patient, a definite financial plan within existing hospital policies. Admitting clerks ascertain who is to receive the weekly bill when it is not to be sent to the patient in the hospital.

The **admitting clerk** (insofar as possible the one who has admitted the patient) follows up the first unpaid weekly statement within 48 hours, obtains payment, reinstitutes the financial plan, or prepares a new, revised plan of payment prior to the submission of the next weekly statement.

The **insurance clerk** prepares, processes and follows up insurance claims. Claims unpaid 30 days after filing are followed up as delinquent accounts. The insurance clerk also processes welfare claims. Claims unpaid 30 days after discharge of the patient, or after receipt of a welfare payment, are followed as delinquent accounts.

The **accounts receivable clerk** prepares, processes, follows up:

1. **Wage Assignments,** which are forwarded promptly to employers and followed up monthly. When the wage assignment is arranged in the admitting office with the understanding that payments are to begin the first pay period after discharge, the patient is advised that the assignment is to be forwarded to the employer within 10 days if payments are not received as planned.

2. **Workmen's Compensation Claims.** Claims unpaid 30 days after filing the papers are followed up as delinquent accounts.

3. **Unsecured Accounts.** These accounts may be considered delinquent when a predetermined schedule of payments is not followed. Careful control and prompt action are necessary to keep accounts current.

The **preadmission-outpatient clerk** handles preadmissions, outpatients and associated activities to relieve congestion in the admitting office:

1. By preadmitting patients on physicians' referrals.

2. By encouraging cash payments for outpatient services.

3. By arranging for payment of accounts by all outpatients, explaining means of payment, and following them up.

4. By auditing daily outpatient charge tickets for laboratory, x-ray, emergency and physical therapy, to pick up lost charges.

5. By completing insurance papers for patients who have been discharged previously.

6. By assisting in admitting office when required.

7. By keeping patient register.

The **cashier's** responsibilities are:

1. Accurate preparation of patients' statements from charge tickets.

2. Control of weekly payments:

—By preparing weekly statements for patients on the seventh day after admission and every seventh day thereafter.

—By submitting directly to patients through hospital messenger service the first weekly statement and subsequent statements authorized by the admitting officer.

—By submitting a list of unpaid weekly statements to the admitting office 48 hours after payment is due.

—By preparing a daily list in duplicate of all patients receiving statements.

3. Acceptance of payments according to the plan arranged by the admitting office.

4. Referral of patients to admitting who are unable to comply with prearranged financial plan.

5. Sending delayed charge statements promptly after posting.

6. Compliance with existing refund policy.

7. Referral of unusual circumstances to chief cashier, or assistant administrator.

8. Maintenance of a file of insurance benefits in order to estimate insurance coverages.

to assign rooms, determine credit, maintain the accounts receivable file, and follow up these accounts. This office also defines the general plan of operation and enumerates the terms—that is, a deposit on admission, weekly statements, payment in full on discharge, a schedule of payments, or whatever other method is decided on for successful accomplishment of the job. It is the responsibility of the admitting office to make an individual, mutually satisfactory financial plan with each patient, either at time of admission or at the time the service is performed. This is a personal matter, arranged with consideration of the individual's circumstances. Tact and understanding are essential.

Especially, it is essential that the financial plan should be agreeable to the patient. Insofar as possible, the patient should be induced to suggest the plan of payment. A plan that is not mutually satisfactory, approved by both the patient and the hospital, is unrealistic and unworkable.

Various means for arranging a financial payment plan may be proposed by the admitting clerk or the preadmission-outpatient clerk when the patient requires assistance, such as a bank loan, welfare department approval, a note or wage assignment, or some other appropriate suggestion. The individual financial plan has to be arranged within the framework of existing hospital policies. Usually, there are four possibilities:

1. *A deposit may be obtained:* It is assumed patients admitted to the hospital will pay their hospital bills as rendered, unless other arrangements are made in the admitting office at the time of entering the hospital. When the patient does not have valid insurance or credit a deposit may be required.

2. *A definite schedule of time payments* agreeable to the patient and the hospital may be formulated.

3. *A weekly statement* may be presented while the patient is in the hospital. There will be appropriate follow-up of all delinquent accounts.

4. *The final hospital statement* may be paid in full on discharge.

The implementation of and compliance with the financial plan, such as deposit or weekly payment, while the patient is in the hospital is a good test of its validity. A violation of the agreed on financial plan indicates the need for immediate follow-up and review, or, if necessary, renegotiation with the patient. For example, changing circumstances may necessitate another interview and a revision of the original plan. There should be sufficient flexibility in the mechanics of arranging financial payments so that appropriate adjustments may be made. It is desirable for the admitting clerk who makes the original financial plan to negotiate subsequent revisions if adjustments are required.

It is the responsibility of the admitting office after preparing a plan of payment to assure adherence to it. It is important that pertinent notes concerning financial arrangements and discussions be recorded on the patient's record. Such notes should be initialed and dated.

There are important cost factors involved in all these procedures. In many cases, more "Indians" and fewer "chiefs" could be used; there is a tendency, because this work is so important, to use skilled employes who have the ability to handle each situation as an individual or exceptional case. This type of personnel is difficult to procure and, if available, is usually costly. A satisfactory routine can accommodate the majority of accounts when less experienced and more easily available personnel are trained to do the job. A chief, then, is needed only to handle those accounts that fall outside the routine.

There may be many satisfactory methods of handling accounts receivable. The procedures to be followed have to be custom-made to satisfy local conditions and practices as well as to achieve the intended goals. The establishment of regular procedures and the use of routines enable the bulk of the work to be handled through established channels. This permits more time to be given to the exceptions—the "special handling" cases which come to light quickly in the processing. An increase in number of exceptions usually indicates someone is not doing his job correctly down the line. Since the supervisors handle the exceptions, this offers a good control opportunity for them to observe and evaluate the performance of the people for whom they are responsible.

There is an obvious improvement in community relations when all hospital employes are oriented to their jobs and are instilled with an appreciation of their fellow workers' contributions; and especially when the patient has the security of knowing his position. A thorough understanding—even of the unpleasantness of a large hospital bill—contributes to better patient relationships. These in turn provide a favorable atmosphere for handling accounts receivable. #

Schedule of Communications to Delinquent Patients

Days After Discharge	*Type of Communication*	*Remarks*
1-7 days	a) Hospital statement	a) Patients with unpaid balance and no insurance
	b) Hospital statement with appropriate sticker	b) Patient with a balance not paid by Blue Cross or insurance
15-22 days	a) Hospital statement with appropriate sticker	a) A reminder
	b) Hospital statement with appropriate sticker	b) Acknowledge payment on account and emphasize balance due
22-37 days	First letter	
37-47 days	Second letter	
47-57 days	Merchant's stop notice	A form prepared by the local Merchant's Credit Association advising there is 7 day filing limit before name is submitted to the association
57-67 days	Third letter	Account referred to assistant administrator 10 days after mailing this letter with recommendations to follow up, charge off, start suit, or send to collection agency

What Hospitals Should Know About Malpractice

A discussion of changes in legal thinking and medical practice that have encouraged malpractice litigation and what hospitals and doctors can do to protect themselves

Mark Berke

Mark Berke, administrator of Mount Zion Hospital, San Francisco, was a chiropodist in London, England, before he came to New York as an accountant for the Hospital for Joint Diseases. He got into administrative work at Mount Sinai Hospital, Cleveland, and was administrator of Mount Sinai Hospital in Philadelphia before he assumed his present post in San Francisco in 1952.

A MODERN HOSPITAL ROUND TABLE

EVERYBODY knows that the number of malpractice suits against physicians and hospitals has been increasing rapidly in recent months, and the size of malpractice judgments has increased even more rapidly. Why?

The reasons are buried deep in the changing nature of patient-physician-hospital relationships, most authorities acknowledge. To examine these malpractice problems and study what is being done about them, the Mount Zion Hospital, San Francisco, recently called a group of experts together for a forum on malpractice. Taking part were Lewis Lercara, San Francisco attorney who has represented plaintiffs in a number of malpractice litigations; Howard Hassard, general counsel for the California Medical Association; John Fulton, special representative on malpractice and liability insurance for the California Hospital Association; Dr. Russell Lee, practicing physician who is also director of the Palo Alto Medical Clinic; Dr. Abraham Sirbu, orthopedic surgeon, who is chief of staff at Mount Zion Hospital, and George Dusheck, science writer for the San Francisco *News*. Mark Berke, administrator of Mount Zion, was moderator for the group.

Because of the interest of hospital people in the malpractice problem as it affects both hospitals and physicians, The MODERN HOSPITAL made a recording of the discussion for its readers. A transcript of the discussion, edited to eliminate repetition and irrelevancies, follows.—THE EDITOR.

Mr. Berke: The purpose of this discussion is to explore the problem of malpractice litigation as it affects patients, physicians and hospitals. We hope to examine some of the reasons there's been a steady increase in the number of malpractice suits and the sizes of the judgments awarded; hear about some of the common approaches to the problem by organized medicine, and learn what hospitals are doing to improve standards of care and thereby reduce the risk to patients.

Mr. Lercara: When I was representing defendants 30 years ago, the ordinary cost of a malpractice insurance policy for a physician was something like $25. This year, to obtain a malpractice policy, say, of $100,000 and $300,000, which he must have if he's going to protect himself in view of the type of judgment that may be rendered, the doctor pays something like $650.

What is the cause of this situation? The first cause is the advance of medical science. A doctor encounters many more risks than he did

30 years ago, because then he didn't use certain technics which can cause serious damage at the present time. A perfect example is spinal anesthesia, where some very unfortunate results sometimes occur. When they do, if the plaintiff prevails in a lawsuit you're talking about a $100,000 judgment, or more.

Second, this is an age of specialization. It is not like the age of the general practitioner, when the patient became friendly with the doctor, knew him from the time he was born, and was raised and taken care of by him throughout all his illnesses. At the present time you go to a general practitioner and he looks you over, and the first thing you know you're at a kidney specialist's, or you're at a heart specialist's, or you're at a cancer specialist's. You don't know the specialist. You meet him for the first time; he examines you; and then you're operated on and something goes wrong. There's absolutely no personal feeling between the patient and the specialist, and, therefore, the patient does not hesitate to file a suit if he thinks the doctor is wrong.

I have had many cases that had considerable merit, but the patient would not file against a general practitioner because he was a friend of the family, and they liked him, and they were sorry for him, and they didn't want to cause him any trouble.

A third thing is that medicine is now a business. Your doctor is operating under tremendous expenses. He's interested in making a living just like an attorney or a taxicab driver or anybody else. He's got to operate and function in an office where he makes the most money he can to pay his expenses and so that he can have the nice things of life. The result is that the doctor does not spend the time that should be spent in diagnosis. My experience is that the great majority of cases in which I've been successful could have been avoided if the doctor had spent a little more time in the diagnosis of his patient's condition. But he hasn't had that time, and he delegates duties to nurses and to others who haven't got his qualifications.

The most important reason of all is the fact that doctors are a close-knit organization and refuse to come into court and testify against their brother physicians. There are many reasons for this: (1) The defendant doctor may be a personal friend; (2) subconsciously most doctors feel that a doctor can do no wrong, and (3) the doctor figures, "If I go and testify against him, I may be in a situation next week and he'll testify against me."

So from a self-preservation standpoint doctors would not testify for the plaintiff. Here's what happened. Cases came to our offices which had merit, medically and every other way. We would talk to medical men, friends of ours, on the street, as attorneys, tell them the facts, and they'd even go to the extent in many cases of saying, "That doctor has no right to practice medicine. He shouldn't be a part of the medical profession. What he did was criminal!"

"Well, Doctor, will you testify?"

"Oh, no! I won't testify in this case. I wouldn't dare to testify!"

Lawyers felt that justice did not prevail under those circumstances. Our judges are lawyers, and the judges talked to the lawyers, and they decided: "Something's got to be done about this!" What they did was extend a rule of law—the rule that's called *res ipsa loquitur*, or "the thing speaks for itself." It's a rule of law under which we don't need a doctor to testify, but we still can get to a jury.

Mr. Hassard: For centuries our courts have held: "A physician does not warrant, guarantee or insure a good result; or that he will effect a cure; or even that his treatment will be beneficial. A physician is not an insurer of the patient's life, and he is not an insurer against mishaps or unusual consequences."

This was the law until about 20 years ago. Then the courts started whittling away at the centuries-old rule. First in x-ray burn cases, and in foreign body cases, the courts by applying the maxim *res ipsa loquitur* presumed the physician's guilt and forced him to carry the burden of establishing his innocence. This concept has now been extended to all surgical mishaps.

Second: In recent years judges have been inclined to allow juries to speculate as to a physician's conduct on the basis of the "common knowledge of laymen." In one recent case the court went so far as to say that: "It is a matter of common knowledge that a bad result doesn't follow an injection, unless the doctor was negligent." This ignores the whole body of medical knowledge on the subject.

Lewis E. Lercara

Lewis E. Lercara was born in San Francisco and received his LL.D. degree from Hastings College of Law in 1928. After admission to the bar in the same year, he was associated with a law firm which represented malpractice insurance companies and defended such cases. After leaving this firm he developed his present specialty —handling malpractice actions for the plaintiff.

Without doubt these new impositions of liability on physicians stemmed from the conviction of many judges that a conspiracy of silence exists among medical men. To even the scales, the rules had to be changed. One recent California appellate court decision discusses this point quite frankly and warns against going too far in holding physicians liable for results over which they have no control. The court said:

"To apply *res ipsa loquitur* in all cases where an unexpected result occurs would hamstring the development of medical science. No medical man would dare to use new procedures, especially in surgery, because if injury resulted he would be prima-facie guilty of negligence."

To demonstrate that a conspiracy of silence does not exist, the California Medical Association and the State Bar of California have launched a joint undertaking called "medical expert panels." This new system provides a panel of physicians in each community selected jointly by the local medical and bar associations, available for consultation when any attorney has a client who is dissatisfied with medical treatment, and available if necessary for expert testimony if a lawsuit develops.

Mr. Fulton: The group approach to this problem by the hospitals in California began four years ago when we found our hospitals in California with a serious situation concerning the excess cost of professional liability insurance. This, like any other cost in a nonprofit hospital, was passed on to the patient, and it was going up constantly.

Several hospitals in California found it impossible to buy insurance and were debating whether they should close their doors. Other hospitals were at the mercy of unknown foreign insurance carriers. Their policies were limited; there were many restrictions. If they wanted their employes covered they had to pay an exorbitant cost; they had no coverage for their volunteers. Then the California Hospital Association put together this group program. They now have full coverage for their hospitals and for the acts of employes of the hospital; they also have full coverage for the individual employe and volunteers; the policy includes elevator, product and premise liability. This is what the hospitals wanted and it's what they felt they needed.

A group insurance program provides California hospitals with full liability coverage. To keep costs down, they work to reduce claims.

It was recognized, of course, that the excessive number of claims was increasing the premiums. Reduce the number of claims and we'd have our premiums down. I'd like to give an example of how this group has attacked the problems in their hospitals:

A familiar problem in hospitals has been, for years, sponges lost during operations. It's an old problem with surgeons; it's an old problem with hospitals. Investigating this was a simple procedure: How many times were the sponges counted? It was found they were counted three, four or five times prior to surgery. After surgery, how many times were they counted? Once.

The California Hospital Association Insurance Council recommended to the hospitals and nurses involved that they should proceed to count again and again, if necessary. They now have what is called a "skin closure count." This count, we can prove by our statistics, has reduced the sponge count problem in hospitals by 70 per cent in the last two years.

Working with such problems as this, we also found another major consideration that many people forget exists in a hospital—that is, we're dealing with a personal service in the hospital. The human beings involved are subject to error.

For example, we talked to one nurse who was involved in a costly mistake. She said: "You might not know, but that morning just prior to going into this particular surgery, I had a call from the doctor of my child. I was informed that my child had leukemia."

Naturally, the emotional problem affected her in her work.

"Why didn't you withdraw from the case?" we asked. "What were you doing at work that day?"

"I'd been off work too long," she said. "I need the money. I couldn't afford to lay off another day."

She worked. She made a mistake. These are the human, emotional

Duty of a Hospital

It is the duty of a hospital toward a person received as a patient to use, and to have used, reasonable care in each of the following particulars of service:

In the selection of employes who are to take part or whose duties will be to take part in ministering to the patient;

In providing for and attending to the needs and comfort of the patient;

In supplying to those charged with the care and treatment of the patient such suitable supplies, equipment and facilities as will be commensurate with the needs of the case;

In maintaining in safe condition and repair any equipment and facilities the use of which by, for or with the patient would be anticipated in the exercise of reasonable care.

If [the hospital] undertakes through the agency of any person in its employ to render to the patient the services of a physician, surgeon or nurse, its duty is to perform such services in accordance with the standards of care required by law of a physician, surgeon or nurse, respectively.

—Instructions to jury in malpractice action

problems that we must live with in our hospitals day by day. There are many other kinds of problems that have been studied in this group approach by the hospitals to eliminate various types of errors, such as identification of patients. In a hospital of 450 beds it's impossible for everybody to know all the patients; we must have some positive method of identifying our patients.

We have another problem that we've spent considerable time on—the age-old problem of bed rails, that we've known in the hospitals for years. The insurance committee of the California Hospital Association attacked this problem. They investigated it. They talked to hospital administrators. They talked to the equipment supply men who sold bed rails to the hospitals, and studied it in every way possible.

In response to concerted efforts by the hospitals, manufacturers came up with a new type of bed rail. I talked to an administrator just the other day. He said: "I had to spend $12,000 on account of your recommendation for new bed rails!"

Looking over our statistics, we know that our rate of injury from various types of incidents has decreased, and we know our patient care has improved. The program has been tremendously successful. Look at the hospitals' insurance rates: Premiums have held the line for the last four years; in 1955 they were reduced 10 per cent.

We know there will be mistakes in our hospital in the future. We know that we cannot tell the employes as they walk into the hospital: "Please, leave your personal and emotional problems at the time clock; don't take them to surgery; don't take them to the nursing station." That would be impossible. But as long as we are working with the problem we feel we are going to promote patient safety in our hospitals. We are doing something about malpractice!

Howard Hassard

Howard Hassard is a graduate of the University of California and that university's school of jurisprudence. He has practiced law in San Francisco since 1934 and is general counsel for the California Medical Association, the California Physicians' Service, and for a number of medical societies and affiliated organizations such as blood banks and the California division of the American Cancer Society.

Mr. Dusheck: Patients are the ones who get cut up and damaged by these surgeons and doctors, when the doctor has had insufficient training, or when the doctor has been careless, or when the doctor has approached the patient under the influence of alcohol, or when the doctor does any one of a number of things which as a human being he sometimes does. Naturally the public is concerned. They're the ones who are hurt.

What causes malpractice suits? Mistakes!

Naturally the public is concerned. It is the patients who get cut up and damaged when a doctor or a hospital makes a mistake.

It's true that newspapers usually do not publicize malpractice suits. I think this is a good thing. The physician has a great deal at stake—his reputation, among other things. His future practice may be ruined by unfair publicity. It's only fair for us to wait until it has been proved by a jury that he actually committed the things he is charged with.

I advocate this, and we follow it on the *News*. But, I'm not too sure of it in one respect: Is the doctor really different from other people? Does he deserve a break which the driver of an automobile doesn't get? We don't hesitate to put a man's name in the paper if he's arrested for drunk driving, even though it may turn out some weeks later that he's acquitted by the court or the jury before whom he appears. Is it right to separate doctors from the rest of mankind? In this instance, maybe a good case can be made out for this.

Someone suggested that there's a feedback in this matter: If we give too much publicity to malpractice it's going to cause people to file more suits. Well, these suits are very carefully screened. First in the lawyer's office. Mr. Lercara will tell us that he rejects many more suits than he accepts. Later on, it's screened by the medical society—especially when this panel system goes into effect. Finally, it gets into the courts. So there is protection all the way along the line.

Mr. Hassard referred to *res ipsa loquitur*. Thoreau referred to this too. He said: "There are some cases of circumstantial evidence that are overwhelming, as when we find a trout in the milk." The same thing applies to sponges that you find inside the patient. I was delighted to hear Mr. Fulton acknowledge that this was considered an error in the hospital. I was under the impression that they arrested the patient for stealing the sponges!

In place of *res ipsa loquitur*, it has been proposed that we have *caveat emptor*, "Let the buyer beware!" A doctor in Los Angeles suggested that the patient be required to sign a consent sheet, like this:

"1. I understand that the operation proposed in my case is a cervi-

cal laminectomy, that is, opening of the spinal canal, inspection of the spinal cord, and . . . covering of the neck . . . by the use of such sutures as are indicated.

"2. The clinical outcome in my case is directly in proportion to the nature of the pathology.

"3. My condition therefore may: (a) be improved, (b) remain stationary, (c) become aggravated with respect to motor power disturbances and sensations or control of sphincters—bladder, rectal or both.

"The above has been readily explained to me, and I accept responsibility for these or any other complications which may arise during or following this surgical procedure which is performed at my request."

This is a clear attempt to take the responsibility off the surgeon and place it on the patient. No matter what goes wrong, you accept it!

I think this is a splendid idea. I'm going to use it in my business, too: "*Consent Sheet for Medical Story in the News.*

"1. I understand that George Dusheck, medical writer for the *News*, will write an article concerning my research on, 'The Effects of Double Martinis on the Semicircular Canals of Golden Hamsters.'

"2. That the results of publishing this article will vary according to the pressure of the day's news; the temper of the copy reader, and the understanding of the reader.

"3. The article may therefore: (a) increase my prestige and scientific status in a gratifying degree, bringing me kudos from all over the world and a million dollar grant from the Rockefeller Foundation plus hundreds of new patients; (b) be unnoticed by anybody, or (c) bring thousands of Golden Hamsters to my office demanding double martinis."

I'm going to ask all doctors to sign this before I interview them.

Dr. Lee: The primary cause of malpractice suits is malpractice; there's no question about that. The first responsibility for this situation is with the doctors. From the public's point of view, the situation is bad.

First, it's expensive. These $600 charges for insurance get passed on to patients in due course of time, just as all other taxes and expenses are passed on to the public. It makes medical care more expensive.

Another bad result to the public is that malpractice threats seriously cripple and jeopardize the enterprising doctor. The enterprising doctor who is willing to try some of these new things—and only by trying them do you find out if they're good—is seriously handicapped by the threat of malpractice.

The medical profession has a responsibility to stop malpractice by producing better doctors. The quality of doctors now is much better than it ever was before. They should not indulge in malpractice. When they do, the medical profession should be the first to condemn them. Really they're the only people who are competent to condemn them. The ordinary jury is completely incompetent to condemn a person for malpractice. We know that. We've seen doctors get acquitted when we knew very well they had committed malpractice.

Doctors should be willing to testify. The complaint of the attorneys is perfectly sound. Doctors should testify when there really is malpractice, and testify with complete honesty. We are at fault in this conspiracy of silence. I'm sure of that.

On the other hand, attorneys are also at fault for this situation—perhaps in greater degree. Many of the suits are based not on the facts of the situation, whether there is malpractice, but whether under conditions of sentimental surroundings we can get a verdict. I've heard an attorney say: "I would rather have a good client than a good case." That expresses the attitude that is frequently adopted by the attorneys, whether the case is valid or not.

The doctor does not have proper protection from these trivial suits, and within the last year doctors in my clinic twice have been named in the newspapers before the case was tried. Trivial suits should not be prosecuted, and attorneys themselves should penalize attorneys who engage in them. I think the principal source of the evil is the contingent fee. Attorneys should not get a percentage of the award. They should serve with the best of their ability whether the case is won or not. They should get a fee of $25 an hour for the work they do in their office, and $50 an hour for the work they do in court, regardless of the size of the judgment. It would make a great difference in the filing of these trival suits. (*Continued on Next Page*)

Jack Fulton

Jack Fulton received his A.B. from Western Reserve University at Cleveland and his LL.B. from Southwestern University of Los Angeles. After four years' service as business manager of a hospital, he undertook accident prevention work with the firm that writes the California Hospital Association's personal liability insurance program.

Duty of a Physician

By undertaking professional service for a patient, a physician or surgeon impliedly represents that he possesses, and it is his duty to possess, that degree of learning and skill ordinarily possessed by physicians and surgeons of good standing practicing in the same locality under similar circumstances. It is his further duty to use the care ordinarily exercised in like cases by reputable members of his profession practicing in the same locality under similar circumstances, and to use reasonable diligence and his best judgment, in the exercise of his skill and the application of his learning, in an effort to accomplish the purpose for which he is employed.

A violation of any of those duties is a form of negligence that we call "malpractice." If you should find that an attendant fails in any of these duties and that such failure was a proximate cause of injury to the plaintiff, then your verdict must be in the plaintiff's favor, as against said defendant.

—Instructions to jury in malpractice action

George Dusheck

George Dusheck, who was born in Chicago and educated at Elmhurst College, has been a reporter and science writer for the San Francisco News *for more than 10 years. He is a member of the National Association of Science Writers and writes a weekly column for his newspaper called "The Medicine Chest." His interest in the subject of malpractice resulted in a series of articles published recently in the* News.

Negligence

Negligence is the omission to do something which an ordinarily prudent person would have done under the circumstances, or the doing of something which such a person would not have done under the same circumstances. It is the failure to use ordinary care or skill, of one sought to be charged with negligence, in the management of his property or person. It is not absolute, or intrinsic, but always related to some circumstance of time, place or person.

—Instructions to jury in malpractice action

In any case, the jury should be informed in advance what percentage of the fee the attorney is going to have. That would make a difference, too!

The judges also bear some responsibility. The application of *res ipsa loquitur* is in general iniquitous. We know that's completely invalid in medical things. The thing does *not* speak for itself in many, many instances, and the application of that doctrine has resulted in serious injustice to physicians and hospitals.

I think it is proper procedure in certain cases that the patient should share some of these risks. It should be perfectly possible for the patient and the doctor to agree: "This is hazardous; something may happen; we think it should be done but it is risky; and you must agree if I'm going to take this chance that you also will take the chance and go along." That kind of agreement should be possible.

Dr. Sirbu: Actually, there's nothing more lonely than the physician who has a suit pending—in spite of this closed corporation that we've heard about. When a man has his professional judgment and integrity challenged, he is affected psychologically. I'm not ready to accept the fact that malpractice is due to the mistakes of doctors. There's much more to it than that. It's a sociological problem because it interferes with the relationship between the doctor and the patient.

If the doctor ignores medical advances and practices only according to the long-standing custom of his community, he is less likely to be sued.

The threat of malpractice hangs over an enterprising and well trained surgeon or medical man who wants to improve, and not just stay at the level of common custom in his locality. He won't be sued if he practices the same way that has been the custom in his community for 20 or 30 years. But he wants to advance; he wants his patients to advance; he wants medicine to advance. If he is going to have this sword hanging over him with just a thin thread, then it's going to affect his judgment about advances.

This is not just in surgery; it's in all of medicine. Miracle drugs are improving now, but you're in trouble if you use them and there's trouble if you don't. If you use the antibiotics to prevent supposed infections and you get a reaction, then you're going to be sued because you used it too much. On the other hand, if you don't use a drug prophylactically, preoperatively or postoperatively, and you get an infection, then you're going to be sued, too!

What does the hospital do about it? Mount Zion is no different than any other hospital that's accredited. We have very stringent rules, and we do this to protect the patient. When a new doctor applies to go on the staff a credentials committee looks into his background; what he's done, how much training he's had—and then he is permitted to be on the staff if he qualifies.

This credentials committee has been in existence for many years in our hospital and other hospitals. We do police the surgeon and the medical man who are practicing in the hospital. Surveillance is the keynote. A man is helped to do the things that he believes he can do; he's given an opportunity. We have constant postgraduate courses, conferences, demonstrations—learning from one another.

Mr. Lercara: I'd like to ask a question of Dr. Lee about contingent fees as a cause of malpractice actions. What would happen if Mr. Jones came into my office. Mr. Jones is a working man. He hasn't got a dime in the bank. Somebody's left some forceps in his wife; and he has a claim. That is a meritorious claim; anybody will acknowledge that it is. I say to him:

"Now Mr. Jones, this lawsuit is going to cost you $1500 and costs, because we have to pay jury fees; we have to pay for depositions; we have to pay for this, that and the other thing. The time I'll put in on this case will amount to $4000 or $5000 at $25 an hour for my time in the office and $50 an hour in court. Mr. Jones, I'll be very happy if you'd pay me that money."

Mr. Jones hasn't got a dime. Now, do you think Mr. Jones should have to walk out of the office? Or do you think he is being aided by the fact that some lawyer is willing to gamble his own money and his own time in presenting his case to a jury in an attempt to obtain remuneration for the loss he has suffered? What would your answer be?

Dr. Lee: If he should win, you should take the $4000 which you put up for expenses, and then take your proper fee.

Mr. Berke: Is there any standard or acceptable fee on a contingent basis?

Mr. Lercara: It's generally recognized in personal injury cases that if the case is settled out of court the fee is one-third. If a case is filed or tried, it's 40 per cent. But it must be remembered that for every large verdict resulting in a big fee there are thousands of cases where the judgment is $2500, and the lawyer gets a third of that, or 40 per cent—$800 or $900. The lawyer would much rather be paid on the basis of $25 an hour!

But why should a plaintiff, or plaintiff's attorney, be required to have a doctor go to this panel to get their O.K.—or else be ostracized if he goes into court and testifies his honest convicitions? If you're suing a contractor you bring in expert contractors; if you're suing an architect you do the same thing.

Mr. Hassard: I'm glad you mentioned architects in the course of your statement, because I once had a case against an architect. I got lots of them to tell me in my office that I had a very fine case, but I couldn't get a single architect in the state of California to take the witness stand! I felt it was human nature. I don't think you'd get shoemakers, bakers, lawyers, doctors, or anybody in a common profession or trade who likes to be involved in one of his fellow's troubles. Mr. Dusheck and one or two others made the broad generalization that malpractice cases are caused by physicians' mistakes. Having been intimately involved in hundreds of them, I know that malpractice is one of the causes, but far from the sole cause. Some of the other causes are greed on the part of the patient, psychotic disturbances, and in some cases just the feeling on the part of a person that because the result wasn't what he or she expected, something must have been wrong with the doctor's care.

Mr. Lercara: Of course there are such things as unjust claims. But isn't it true that the majority of malpractice cases that are won in court are justified cases? I'm talking about the big majority of cases where a jury gives the plaintiff the verdict. Wouldn't you say from your experience that the majority of those were meritorious cases?

Mr. Hassard: I would say that the cases that result in a verdict by a jury against a physician can be put into two categories: (1) those in which the services performed by the physician lacked skill or care; and (2) those in which the jury was swayed by sympathy aroused by the fact that the plaintiff was a person who was injured.

A paralytic, for example, draws intense emotional sympathy from any group of people. It's easy for people to be swayed emotionally and forget the instructions that the judge gives them, which are: that you are to judge, not on your sympathy for an individual, but on whether or not due care was used.

Mr. Dusheck: Well, let us assume that the doctor has not been at fault, but you still have this paralyzed person. What does organized medicine believe should be done about this person?

Mr. Hassard: The problem that you're bringing up is a problem for all of us, and it's not limited to physicians or medical malpractice. It runs across the entire field of personal injuries. There are many people, including a number of lawyers, and I happen to be one of those, who believes that in the course of time society must take care of disabling injuries on the same basis that is now done in industrial injuries—that is, the workmen's compensation system. But that is not the law today. That is a social problem for the future.

Mr. Berke: Why not take malpractice cases away from the courts, and place them in the hands of a commission, comparable with the handling of workmen's compensation cases? The commission would then judge what award should be given the patient, if any.

Mr. Lercara: You can't take malpractice cases as distinct and not consider personal injury cases in the same way. I think that ultimately —it may be 20 years from now—we'll have some sort of system whereby people who are injured are going to be paid, not counting the fault one way or another. The malpractice cases are going to be a portion of the personal injury cases generally. I probably will be out of practice in another 10 years, so it won't affect me personally, but from a social standpoint I think that probably it's a very desirable thing, as workmen's compensation is. *(Continued on Next Page)*

Dr. Russell V. A. Lee

Dr. Russell V. A. Lee was born in Utah, graduated from the University of California in 1917, and received his medical degree from Stanford University after service with the army in World War I. He is president of the Palo Alto Clinic and of the Palo Alto Medical Research Foundation and is clinical professor of medicine at Stanford. He has five children, all doctors.

Dr. Lee: There's been a recent study by the California Medical Association of the psychological aspects of malpractice, and it brought out that there are certain personality traits in people who sue a doctor, and on the other hand there are some personality traits in doctors who are being sued. So there is more to it than just the mistakes of doctors!

Mr. Berke: Are there actually more malpractice cases in California than other states, or are the judgments larger, or are they more played up?

Mr. Hassard: Statistically, California, New York, the District of Columbia, and Florida have the highest incidence of malpractice suits in the country.

It is perfectly true that one "jumbo" verdict creates 10,000 times more comment than 10,000 moderate verdicts, and there is no question about the direct relationship, in any community, between an extremely large verdict and the number of people who go to lawyers and want to sue!

Mr. Berke: That reminds me of a case we had at the hospital. A young fellow came in to see me, and he wanted to know the names and addresses of the patients who shared the room with his mother, who was in a four-bed room. It seemed that while she was in the room, one of the lab technicians drew blood from her instead of from another patient. He claimed his mother was severely upset by this. She'd been in a state of "shock" ever since, and he thinks he has a suit against the hospital!

In cases involving risk, the doctor, in order to protect himself and the profession, will have to insist that the patient assume his share of it.

Mr. Dusheck: It's been suggested that the threat or possibility of getting into legal trouble may hamper the kind of treatment that the patient ought to receive. Wouldn't a consent form of the kind we have mentioned set up a kind of barrier in the patient's mind that might lead him to refuse treatment which he should accept?

Dr. Sirbu: I don't think there is any question about it. There is this calculated risk. The doctor must protect himself, and perhaps protect the profession and future patients if he's going to be permitted to practice. So he's trying to get the patient to share the risk. The patient must be made to understand this, or at least the patient's family. These are the things that we have tried to do in our educational program.

Mr. Lercara: Isn't it true that we who have represented the public in this tough fight on malpractice actions have led doctors and hospitals to look at and clean up their own houses—to try to prevent things that were preventable?

Mr. Fulton: We're interested in patient care in our hospitals, and we're constantly working to improve patient care, and this just happens to be one phase of our patient care.

Mr. Lercara: But isn't it true that because there have been many malpractice suits filed where sponges were left in the patient, this called your attention to the fact that they must not be giving this patient the proper care?

Mr. Fulton: I'll give you a qualified yes.

Mr. Berke: I think it's fair to say that when you have a hole in your pocket through which a coin has dropped, you should mend your pocket!

Dr. Lee: There's another part to this that hasn't been mentioned. The threat of malpractice has enormously increased the utilization of x-rays, particularly in the field of orthopedics. The orthopedist knows very well that he doesn't need an x-ray, but he takes one just because this case might get to court some day. The cost of these extra x-rays made necessary by the threat of malpractice, I suspect, is about equal to the malpractice insurance that's carried!

Mr. Berke: Do you think that group practice offers greater security for both patients and physicians in this matter?

Dr. Lee: Yes. Actually a group to protect itself has to scrutinize its members a little more closely than members of the medical profession at large are scrutinized. #

Dr. Abraham B. Sirbu

Dr. Abraham B. Sirbu was graduated from the University of California Medical School in 1928 and is a member of the American Academy of Orthopedic Surgery and the Western Orthopedic Association. He is chief of the department of orthopedic surgery at Mount Zion Hospital, San Francisco, chief of staff of the hospital, and president of the medical board. He is a member of the house of delegates of the California Medical Association.

Each tour guide carries reminder cards with information about each floor. This card describes lobby.

Bishop Clarkson is the first new hospital plant built in Omaha in 26 years.

Guided Tours Lead to Public Understanding

Mrs. Theodore F. Armstrong

GUIDED tours in Omaha's Bishop Clarkson Memorial Hospital, which was opened in December 1955, evolved from the fact that Omahans and other people from this section of the Midwest were eager to see the first completely new general hospital plant to be built in Omaha for 26 years.

However, during the first 18 months, it was realized that regular guided tours through the hospital for patients' relatives and visitors, ambulatory patients, prospective parents, and new personnel requiring orientation was a public relations service that would be valuable to those taking the tours and to the hospital. Interest is stimulated in what goes on behind the scenes; a sense of security about the patients' welfare, resulting from the evident efficiency, safety, adequate equipment, comfort and cleanliness, is assured. When the amount of equipment and number of personnel necessary for patient care are realized, those taking the tour understand where some of the money for hospital care is spent. Perhaps the greatest benefit of all is the psychological effect of seeing and understanding hospital routine, which helps to eliminate the apprehension one sometimes feels upon entering a hospital as a patient.

See next page for additional text and the tour in pictures

Mrs. Armstrong is chairman of the tour guides committee, Hospital Service League, Bishop Clarkson Memorial Hospital, Omaha, Neb.

A tour starts in the lobby with a short talk on the history of the hospital. The guide introduces herself as a volunteer.

Air conditioning, automatic beds, piped oxygen, and other items which affect patients are pointed out in a room.

The author, above, shows a group the new babies in the fourth-floor nursery. Below, a group tours laboratories.

WELL TRAINED GUIDES CONDUCT

THE Clarkson Hospital one-hour tours are held on Wednesdays at 2 p.m. They are advertised by an easel sign in the lobby and also in the elevator receptacles one day a week. No advance registration is required. From two to 15 people usually show up, although about twice a month, a dinner costing from $1.50 to $2 is booked for large groups—from 40 to 100 persons—such as the Women's Chamber of Commerce, the Telephone Pioneers of America, or a church group. A short business meeting is held, and Administrator Hal G. Perrin and/or his assistant, James Canedy, talk for a total of 30 minutes. Then tours are conducted, with the trained guides assisting.

Clarkson Hospital's Service League auxiliary members act as guides. They are uniformed in the Service League's golfer type of dress of an aquamarine hue that harmonizes with the décor of the lobby floor. The guide's personality has much to do with the success of the tours; she should be gracious, friendly and dignified. She should have a good speaking voice and be especially careful to make herself understood. One guide to every 10 persons is a good average. One of the touring group may be asked to help keep the group together and to close doors.

The tours originate in the main lobby lounge, with a two- or three-minute prefacing talk about the background and history of the former hospital and the present new building. The guide introduces herself by name, to establish a friendly atmosphere, and identifies herself as a member of the auxiliary volunteers who also staff the gift shop and information desk at the hospital.

As the chapel is the nearest point of interest, it is visited first, and rightly so, since the hospital is under the auspices of the Protestant Episcopal Church of Nebraska. Also on this floor are the patients' registration office; business offices; lounges for personnel, volunteers and doctors; the pharmacy; medical records office; gift shop; coffee shop for the public, and personnel and staff dining rooms.

Elevators are used to go to one of the top six patient floors. The first stop is the nurses' station, where the pneumatic tube system, the patient-nurse intercommunication system (demonstrated later from a room), and the dual dumb-waiters that come up through pharmacy and central supply are shown.

An unoccupied room, if available, is then visited.

In the hematology section, a tour group watches some blood analyses and looks in at the tissue laboratory.

COMPLETE TOUR OF THIS 275 BED HOSPITAL IN ONLY HALF AN HOUR

Those things that immediately affect the comfort and safety of the patient are demonstrated: piped-in oxygen, extra-long motor driven beds, individual controls on year-round air conditioning, emergency call buttons in the bathrooms, patient-nurse intercommunication system, sound absorbent ceiling. The inevitable questions about room rates are answered at this time.

A visit to the maternity floor and the nursery delights everyone, prospective parents most of all. Anyone under 16 is asked to by-pass the maternity floor and to await the tour in the third floor lounge. Incidentally, if the group includes any aged or infirm persons, or any women in the last months of pregnancy, the elevators are used exclusively for their safety. Otherwise, the group is taken through several housekeeping service corridors, where they see linen rooms that supply the 15 pounds of clean linen per patient per day; facilities for taking care of patients' flowers; soiled clothes chutes, trash chutes, and so on.

The next floor below houses the x-ray department and the laboratories. The visitors see the units that are used for making x-ray pictures, facilities for x-ray therapy, and storage space for radioactive materials. As the guests walk down the corridor looking in the open doors of laboratories for serology, hematology, tissue and pathology, the guide describes in a very general way the part the hospital laboratory plays during the patient's stay.

The surgical floor follows and, as no one in street clothes is allowed within this restricted area, the guide swings the doors open wide and from this position explains the function of central supply, located in the center of a U-shaped wing and flanked by 14 general and specialized operating rooms. Emphasis is placed upon the value of a well equipped recovery room large enough for a hospital of this size (300 beds).

An elevator is taken from the second floor past the lobby floor to the ground floor, where the group is shown the ambulance entrance and emergency room, which is staffed day and night. The physical-therapy department is also on this floor, and the visitors are surprised at the number of mechanical aids that are found here, under the main lobby. The area is flooded with perpetual sunshine—yellow walls and curtains and green vines—and is a radiantly cheerful place.

The tour ends in a department in which everyone is interested—the kitchen. Visitors inspect the air-line type of food carts with hot and cold compartments, selective menus, colored diet tags, dishwasher, large food mixers, walk-in refrigerators, and ovens and remark on the cleanliness of everything.

Of course, many questions are asked, and as many as possible are answered on the spot. How did the hospital get its name? How many people work here? Where can I get a picture like the one in the fourth floor lounge? How many babies are in the nursery? How long are they kept in the incubators? Would it be possible for me to see the elevator controls? (Yes, he did—an appointment with the engineer was arranged for the following morning!) What is the material in this floor? What kind of marble is used in the lobby and where did it come from? How much did the building cost? How much for equipment? Who designed the art work?

People love statistics—the number of procedures in the laboratory last year, the number of dishes washed per hour in the gigantic dishwasher, the ratio of employes per patient, the amount spent for sutures, for coffee, for electricity, ad infinitum!

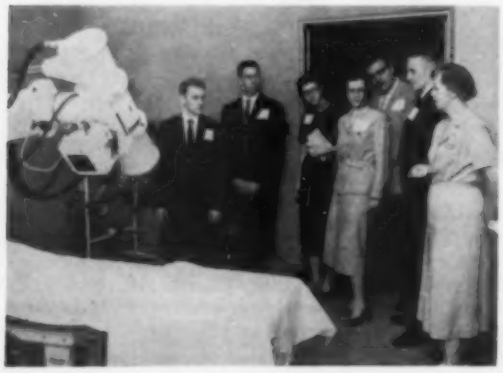
The training program for the first guides consisted of a tour—longer and more comprehensive than the one described—and a lecture based on study material. This material consisted of five pages in outline form, covering the details of every floor visited and a code of ethics which precludes any guide from discussing confidential matters concerning the hospital or the patients with others. This required about three hours altogether.

A new guide is now trained by studying the instruction material and by going on several tours until she feels confident she can lead one. This varies from two to four times, and at least one of these should be with the tour guide chairman, as she is responsible for the success of the training and cooperation of her volunteer group.

Reminder cards, small enough (3 by 5 inches) to fit into a pocket or one's hand, with important facts about each floor or area typed or mimeographed, have been useful to the guides.

Conducted tours enable a hospital to interpret its complex organization to the general public. By this means the people served by the hospital are shown that patients will receive good care in comfort and safety. #

The powerful moving beam, deep therapy apparatus in the radiology center on the second floor is shown.



Air controls and temperature warning devices are explained by the chief engineer in his ground floor office.

ABOUT PEOPLE

Administrators


Donald M. Rosenberger

Donald M. Rosenberger, director of Maine Medical Center, Portland, has been appointed director of United Hospitals of Newark, N.J., a consolidation of Presbyterian Hospital, Hospital for Crippled Children, Babies Hospital, and Newark Eye and Ear Infirmary, totaling 600 beds. Mr. Rosenberger was the first director of the Maine Medical Center when it opened in July 1956; previously, he had been director of the old Maine General Hospital for seven years. Before going to Maine, he directed Hamot Hospital, Erie, Pa., for a number of years. He is a fellow of the American College of Hospital Administrators, secretary of the Maine Hospital Association, and active in several hospital association committees. Mr. Rosenberger serves on the faculty of the Colby College Institute for Hospital Administrators, the graduate school of public health at the University of Pittsburgh, and the graduate program in hospital administration at Columbia University. He is a consultant to the editorial board of The MODERN HOSPITAL.


Ladislaus P. Grapski

Ladislaus P. Grapski, associate director and assistant secretary to the board of trustees of Johns Hopkins Hospital, Baltimore, has been appointed director of University Hospital, College Park, Md., effective July 1. He will succeed **Dr. Clifford Blitch,** who is planning to enter private practice in Florida. Dr. Blitch has been director of the hospital since 1954. Prior to his appointment at Johns Hopkins in 1951, Mr. Grapski was director of Loyola University's University Hospital and assistant dean of Stritch School of Medicine, Chicago. He is a fellow of the American College of Hospital Administrators.

Maudie L. Horne has been appointed assistant director of the Intermountain unit of Shriners Hospital, Salt Lake City. Since 1954 Mrs. Horne has been director of nurses at the U.S. Public Health Service Hospital, Tacoma, Wash. She is a graduate of Northwestern University's hospital administration course.

A. J. Woodring has been appointed assistant director of the hospital and clinics of the University of Florida, Gainesville. Previously, he served as assistant administrator at Anderson Memorial Hospital, Anderson, S.C., and as administrator of Fairfield County Hospital, Winnsboro, S.C.

Emory N. Grubbs has been appointed director of James Walker Memorial Hospital, Wilmington, N.C., succeeding **Horace E. Hamilton,** who resigned to become administrator of Spartanburg General Hospital, Spartanburg, S.C. Mr. Grubbs has been associated with the Wilmington hospital for the last 12 years, as controller and as assistant director.

Lee Hough has been appointed administrator of McAuley Hospital, Coos Bay, Ore., succeeding **Joseph L. McGovern,** who resigned to accept a hospital position in Chicago. Mr. Hough previously has been associated with Veterans Administration hospitals, and served as business manager of a hospital in Michigan and in Texas.

James P. Neal has been appointed administrator of Community Hospital of Evanston, Ill., succeeding **Howard F. Cook,** who resigned to become executive secretary of the Chicago Hospital Council. Mr. Neal is now administrator of Wheatley Provident Hospital, Kansas City, Mo. From 1950 to 1956 he was employed at the University of Chicago Clinics, including an assignment in the Argonne Cancer Research Hospital. Mr. Neal is a graduate of Roosevelt University and of the hospital administration course at the University of Chicago.


Robert G. Curran

Robert G. Curran has been appointed administrative assistant at Boston City Hospital, Boston. He is a graduate of the course in hospital administration at the University of Minnesota, and served his administrative residency at Johns Hopkins Hospital, Baltimore. For the last year, Mr. Curran has been administrative assistant at Johns Hopkins. He is a nominee of the American College of Hospital Administrators.


Harold E. Springer

Harold E. Springer has been appointed administrator of Memorial Community Hospital of Edgerton, Wis. Mr. Springer formerly was associated with Presbyterian-St. Luke's Hospital in Chicago as the purchasing agent.

Vincent J. Parrish has been named assistant manager of the Veterans Administration hospital at Erie, Pa. Mr. Parrish formerly served at V.A. hospitals in Iowa City, Iowa, and Downey, Ill. He is a hospital administration graduate of the University of Iowa.


Ronald W. B. Wyatt

Ronald W. B. Wyatt has been named administrative assistant at Merritt Hospital, Oakland, Calif. Formerly, he was administrative resident at San Diego County Hospital, San Diego, and administrative intern at Peralta Hospital, Oakland, Calif. Mr. Wyatt received his bachelor's degree and a master's degree in hospital administration from the University of California.

Harry Davis, administrator of Montfort Jones Memorial Hospital, Kosciusko, Miss., has been named administrator of Simpson County Hospital, now under construction in Mendenhall, Miss. **Tom Logue** was appointed assistant administrator of the new hospital. At present he is laboratory and x-ray technician at Covington County Hospital, Collins, Miss.

Agnes Wyss has been appointed directress of the Weld County Home for the Aged, Greeley, Colo. She formerly was superintendent of Yuma County Hospital, Yuma, Colo.

Louise Cooper, R.N., superintendent of Fort Morgan Community Hospital, Fort Morgan, Colo., since 1953, has been appointed superintendent of Livingston Memorial Hospital, Livingston, Mont. **Mrs. Henry Levy** has been named to succeed Miss Cooper at the Fort Morgan hospital.

John A. Taft Jr. has been appointed assistant administrator of Delnor Hospital, St. Charles, Ill. Mr. Taft formerly was evening administrative assistant at Chicago Wesley Memorial Hospital. *(Cont. on p. 158)*

How to Make Presentees Out of Absentees

Control of absenteeism in the hospital must be established on four levels: administration, department supervisor, personnel department, and employe health service. All levels, however, are ultimately the responsibility of top management; the administrator must determine that control of absenteeism is being carried out to his satisfaction by all individuals concerned.

Ann May

COMPLACENCE with existing absence rates, or even comparison of the hospital's rate with the national absence averages per employe, weakens the administrator's control of absenteeism. It is important to consider what can be done about *any* rate of absenteeism.

In the first section of this study published last month* the causes of absenteeism and a comparison of absentee rates between hospitals and industry were presented. In this issue, emphasis will be on methods of controlling and reducing absenteeism.

Attention must be given to the hospital's responsibility for control through four groups—the administration, department heads, personnel department, and employe health service. The administrator has the ultimate responsibility for seeing to it that duties are carried out in all areas, and he must consider the problem of absenteeism in terms of the actions possible on all levels.

ADMINISTRATION

Emphasis on "presenteeism" by recognition of good attendance records should be an element of policy originating with top management and reflected through all personnel levels down to each individual employe. Good records should be recognized by management, using such methods as individual congratulations, bulletin board announcements, stories in employe publications, and other means.

Incentive plans or merit awards also are effective. For example, a One Thousand Hour Club, with insignia such as pins and rings, offers constant public recognition at the working level.

Granting cumulative sick leave may help reduce absences. The schedule may call for an allowance of days off for good attendance for salaried employes after six months' employment and for hourly wage employes after 12 months. One day off for personal business may be granted for every three months of perfect attendance. Such remuneration in all of its various forms is a definite incentive to good attendance.

Top management also has responsibility in the area of good human relations. This includes supervisory training and development, and interpreting, analyzing and properly meeting the causes and factors of absenteeism. Each case is an individual problem and requires an individual remedy.

Proper division of responsibility is important. Good attendance is everyone's business, and it is especially necessary in good patient care. The administrator must see to it that responsibility is suitably divided among the administration, supervisors, personnel department, and health service.

There are many factors the administration must consider, since they may affect the employe's attitude toward his job and the hospital, including those mentioned in the following paragraphs:

Annual wage surveys of the local community should be made, including business and industry as well as other hospitals, to make sure that salaries are comparable.

There must be good working conditions, such as proper lighting, room temperature, and sanitation. Of course, the equipment needed to do the job, such as machines and uniforms, should be provided, and the dining area, lounges and other facilities should be acceptable.

Among the hospital's personnel policies that should be studied by administration are: the insurance program, recreation sponsored by the hospital, pension and retirement funds, hospital discounts for employes and dependents, social security, workmen's compensation, and income tax service.

Sick leaves, paid holidays, vacations and remuneration for overtime work (whether cash or time off) should be carefully defined for all employes.

The administrator should make sure that police protection is available, if the hospital is located in a blighted section. He should determine whether local transportation is adequate, and should learn whether nursery schools for the convenience of married women are accessible.

He should actively support safety, health and security programs to build full-time attendance and minimize absences.

One direct approach to the problem of absenteeism is the use of disciplinary clauses in collective bargaining agreements. While unions as such do not exist generally in the hospital field, conditions may be considered analogous in many aspects. The object

*May, Ann: Absenteeism Survey: Hospitals and Industry. Mod. Hosp. 90:87 (May) 1958.

Miss May is administrator of Schoolcraft Memorial Hospital, Manistique, Mich.

of such a disciplinary clause is to reduce avoidable absences by imposing rules and regulations on employes and to provide a check on unavoidable absences. The provisions of absentee clauses may be divided into the following categories: advance notice of absence, advance notice for "just cause" only, enumeration of just causes for absences, and penalties that may be imposed upon habitual absentees.

Another type of contract clause recommended by executives to cut down absenteeism is a provision governing holiday pay. Such clauses usually specify that holiday pay is to be withheld unless an employe had a regular working day before and after the holiday. (The exceptions are holidays falling on Fridays or Mondays. Usually, administration determines the policy of holidays falling on Saturdays and Sundays, whether they are paid holidays or not.)

DEPARTMENT LEVEL

It has been observed that the principal direct responsibility for the control of attendance necessarily falls upon the supervisors. If employes have a consistently poor attendance record, or if many employes in one department contribute to an absence rate that is in excess of the hospital average, the supervisor is responsible for determining the causes, discussing the situation with individual employes, and applying any necessary corrective measures that are permissible within the framework of administrative policy.

Orientation is the supervisor's first responsibility in connection with a new employe. This means starting with the employe's relationship to the department, and placing the department within the framework of the hospital. Orientation to the specific job assignment is important. Woven into this primary training must be the reiteration of the importance of good attendance to the basic objective of good patient care.

Supervisors may either implement or determine policy in these situations: excused and unexcused absences, paid holidays, sick leave, vacations, fringe benefits (if any), advance arrangement for absence to be made when possible, notification of supervisor when advance arrangement is not possible, and a good employe training and development program.

The supervisor should be responsible for work distribution within his department. "Double-tracking" of work not only covers an absentee's function within the department, but also reduces both the resultant inefficiencies and replacement cost involved in absenteeism.

Counseling and guidance are the supervisor's responsibility when an employe's work pattern has changed because of some problem, which may be personal, physical, emotional or related to the job itself.

Employe attitudes have a significant relationship to absence rates. For example, the way a person feels about his supervisor and his associates is a factor common to both wage and salary workers. The way he feels about his financial and job status and about the hospital in general is of considerable importance to a salaried worker. The hourly wage employe cares more about satisfaction with the job itself. These factors of employe attitude may be subject to committee action and remedy.

Disciplinary action, such as oral reprimand, written reprimand, suspension or dismissal, is usually the duty of the supervisor. If a special committee or fact-finding board has been set up for this purpose, the supervisor must refer the employe to it.

Finally, the supervisor should set a good example. Psychologically, behavior of the leader is reflected and consciously imitated by the group where a high esteem for the former prevails.

PERSONNEL DEPARTMENT

In dealing with a new employe, the personnel department should stress the importance of attendance and of reporting absence. This may be done during preliminary and follow-up interviews, induction and orientation.

The personnel department is properly given responsibility for the new employe's orientation to the physical plant of the hospital and a definition of personnel policies in general. The functions of the hospital, the importance of emphasizing patient care, and other basic indoctrination should be part of the orientation program for employes.

Hospital policies of sick leave, paid holidays, vacations, fringe benefits, salaries, tardiness, excused and unexcused absences, insurance, retirement benefits, and any other factors should be clearly and simply defined. The employe's supervisor will continue with orientation to the department, departmental relation to the hospital, and personal adjustment to the job assignment.

A system of individual attendance records should be kept. This means daily recording with careful monthly review of the records of all personnel. This should be done with the cooperation of the supervisor.

Departmental absence rates should be compared with the hospital average each month to observe trends and to detect potential absentees before chronic habits develop.

Regular review of records and charts should be made at quarterly intervals, in addition to the routine monthly review. Attendance records should be part of the agenda of monthly or quarterly management meetings.

The administration may consider adapting machine accounting to absentee records. A valuable by-product of a new machine accounting system for hospitals can be used to place absentee data on accounting cards. This system is being used, for example, at Harper Hospital, Detroit, for payroll, daily census report, perpetual inventory, and medical record statistics. It would be no problem to change over to the mechanization of attendance reporting.

Other functions of the personnel department may include the following:

1. For unexcused absences, the employe may be required to clear his status with the personnel department before returning to work.
2. When arrangement is made in advance for absence, the department head should notify the personnel department, or vice versa as the case may be. When advance notice is not possible, an effort should be made to determine the cause of absence. The supervisor, employe health service representative, or the personnel department person should get in touch with the absent employe by a personal call at his home, by telephone, or by mail.
3. If a reprimand for tardiness or poor attendance results in nonpayment for time lost, the situation and policy should be reviewed by the personnel department to be sure there is no conflict with the wage-hour law.

EMPLOYE HEALTH SERVICE

A preemployment physical examination may serve to eliminate obvious problem cases, those who will be constantly absent for reasons of health. Preventive health service may reduce absenteeism caused by personal illness. Remedial care, on the other hand, may benefit the employe symptomatically without correcting the real cause of illness.

This department may assume responsibility for the use of physicians' or nurses' reports at the beginning and end of an employe's sick leave.

In cases of long or severe illness, the health service may maintain a periodic check on the employe's condition and report any significant development to his supervisor or to the personnel department. If the matter is important, either may then report it to the administration. #

Since buried service lines interlaced the site of the new unit and the ground level had to remain clear, serpentine passageway was designed.

Adaptability is the word for new unit

William P. Cox

THE E. H. Crump Memorial Hospital, Negro unit of the City of Memphis Hospitals, Memphis, Tenn., combines the better features of contemporary hospitals. The goal of the architects and administration was a harmonious, efficient and modern private care unit dovetailed with an older, teaching hospital.

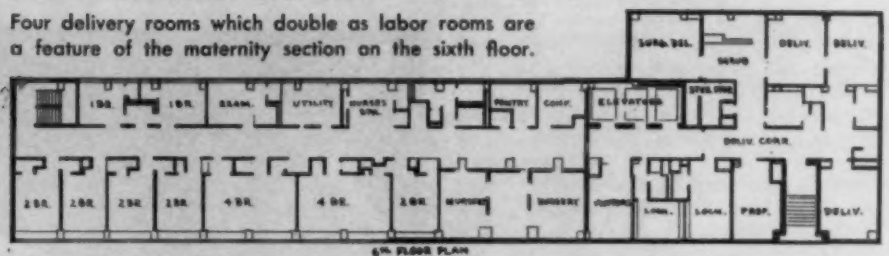
The new unit is connected with the existing John Gaston Hospital and the Thomas F. Gailor Clinic so that full use of special facilities already provided in the 525 bed medical center could be made available without costly duplication. These include the blood bank, record room, radioactive cobalt and therapeutic x-ray department. Crump Memorial has its own operating rooms, delivery rooms, dietary facilities, laboratory, nursing school, student nurse dormitory, and nurseries, but draws the services of laundry, maintenance, power, pathology laboratory, emergency room, and pharmacy from the main plant.

The four major divisions of an acute general hospital were set up to provide service to medical, surgical, obstetric and pediatric patients. Reassignment of space within the building is almost as simple as shifting the furniture. An example of the adaptability of the hospital to demand is that four of the single rooms have the triple function of private care, isolation and psychiatric detention.

For additional photographs, plans and text, see next page

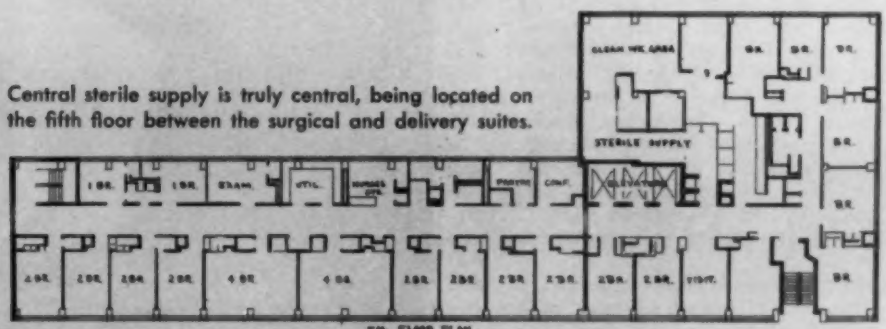
Mr. Cox is a member of the firm of Eason, Anthony, McKinnie and Cox, Memphis, who were architects for design. Norton and Rice of Memphis were architects for supervision. Robert C. Hardy is administrator of City of Memphis Hospitals.

Four delivery rooms which double as labor rooms are a feature of the maternity section on the sixth floor.



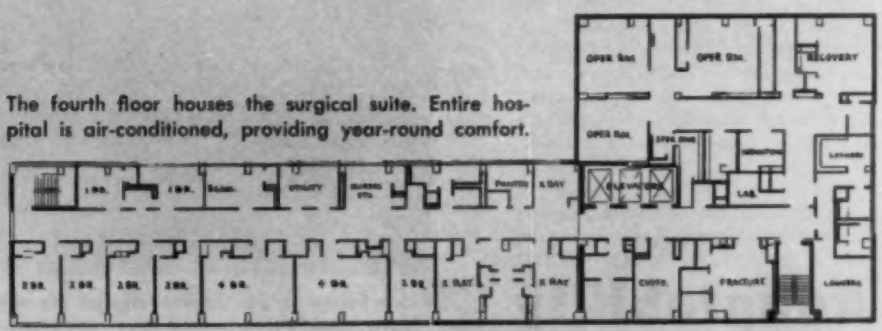
6TH FLOOR PLAN

Central sterile supply is truly central, being located on the fifth floor between the surgical and delivery suites.



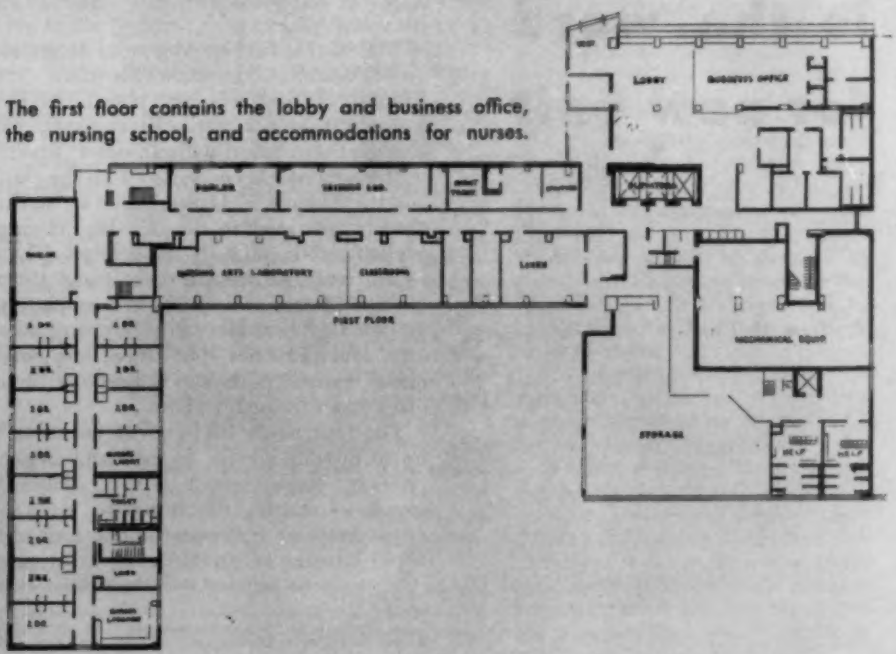
5TH FLOOR PLAN

The fourth floor houses the surgical suite. Entire hospital is air-conditioned, providing year-round comfort.



4TH FLOOR PLAN

The first floor contains the lobby and business office, the nursing school, and accommodations for nurses.



FIRST FLOOR

NEW PRIVATE UNIT WAS DOVETAILED WITH HOSPITAL FOR INDIGENTS

OUTLINE OF CONSTRUCTION COSTS

Total cost (including Group I Equipment)		$2,070,831.38
Number of beds	128	
Cost per bed		$ 16,178.37
Total square feet	99,784	
Square feet per bed	780	
Cost per square foot		$ 20.75
Total cubic content	1,048,091	
Cubic feet per bed	8,188	
Cost per cubic foot		$ 1.97

These square footages and costs include a 66 bed student nurses' dormitory and school, and quarters for 11 interns in the hospital proper. Costs do not include land costs or architectural and engineering fees. Many of the adjunct facilities are designed for an addition of 122 beds.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects, and the state agency. A similar award will be made each month.

SOME features of the Crump Memorial Hospital are interesting solutions to the problems the architects faced. For instance, there is no basement. The site was interlaced with buried service lines that would have been quite costly to reroute. Consequently, the connection to the other hospital units could not go underground. Since access to the inner court of the next building had to remain open for fire-fighting equipment, ambulances and other vehicles, the result was the second floor level serpentine passageway.

The kitchen is on the second floor, in a two-story section of the building. A one-story hydraulic elevator moves raw food up from the storeroom on the main floor. The kitchen is air-conditioned and is daylighted by yard-wide plastic bubbles in the roof. The central tray system is expedited by use of a moving belt tray assembly line.

Patients are housed from the third floor up. This arrangement removes them a comfortable distance from the noises of the street. All patient rooms, except the private rooms, are oriented south away from the street and overlook the court.

The delivery rooms are also labor and recovery room combinations. The patient is prepared in a special room provided for this procedure within the delivery suite. She is then placed on the delivery bed where she spends her period of labor, is delivered, and is observed during postpartum recovery. This is just another idea borrowed from hospitals where the system has been proved.

Central supply is truly central, located on the floor between the surgical and delivery suites and connected to both by the dumb-waiter. It serves not only the needs of surgery and obstetrics, but the nursing units as well.

Since patients have been admitted to the Crump hospital, it has been found that 50 per cent of them were once clinic or inpatients of the City hospital. This substantiates our original theory that the maintenance of medical records in a central file room for the entire hospital complex would prove beneficial. The Crump record room is 28 seconds away from the central file room in the John Gaston Hospital by pneumatic tube, which goes via the second floor passageway and clinic.

The entire hospital is air-conditioned, providing year-round comfort for the patients.

Hospital accommodations are for Negro patients only, but the staff and employes are both Negro and white. This hospital not only cares for those who demand and can pay for modern accommodations but has given employes opportunities for steady and satisfying work.

The main lobby, located on the first floor, is shown to the right. A typical patient corridor, looking west, is shown below. Patients are lodged from the third floor up, with service facilities and the nursing school on first three floors.

A typical patient room, showing two beds in a four-bed room, is seen at right. All patient rooms, except the private rooms, are oriented south, away from the street, and overlook the court and vermiform connection to Gailor clinic.

MEDICINE AND PHARMACY

Society of Hospital Pharmacists Announces New American Hospital Formulary Service

Grover C. Bowles Jr.

HOSPITAL pharmacists from the United States and Canada gathered in Los Angeles, April 20 to 23, for the annual meeting of the American Society of Hospital Pharmacists and its parent organization, the American Pharmaceutical Association.

Highlighting the hospital pharmacy meeting was the announcement of the American Hospital Formulary Service which was to be made available early this fall. In making the announcement, Dr. William M. Heller, director of the formulary service and chief pharmacist of the University of Arkansas Medical Center, stated: "A hospital formulary is a dynamic ever-changing compilation of up-to-date information on modern pharmaceuticals selected with discrimination. To compile it and maintain it in cooperation with the pharmacy and therapeutics committee is one of the foremost responsibilities of the hospital pharmacist. Through the American Hospital Formulary Service, the American Society of Hospital Pharmacists is assisting in this program of improving the handling and use of drugs in hospitals."

The American Hospital Formulary Service will consist of a loose-leaf collection of monographs which the pharmacy and therapeutics committee of each hospital may use in preparing its own formulary. To ensure their accuracy and usefulness these monographs are reviewed by leading hospital pharmacists, pharmacologists and members of other professional groups.

The monographs are headed by the generic name and also list common synonyms and trade names. Pertinent information is given on physical and chemical characteristics, actions and uses, and dosage. Each monograph is completed by a list of the preparations most commonly used in hospitals. Monographs are set up for a pharmacologic-therapeutic classification. An alphabetical index will be renewed each year. General information on prescription writing, conversion tables, poison antidotes, and biochemical tables is included.

More detailed announcement regarding the American Hospital Formulary Service will be made in the pharmaceutical and hospital journals in the near future. Single copies of the formulary will cost approximately $15, which includes supplement service for the first year. Supplement service will be available after the first year for a nominal fee.

Hospital pharmacy's highest award, the Harvey A. K. Whitney Lecture Award, was presented to Walter M. Frazier of Springfield, Ohio, for his outstanding contributions to hospital pharmacy.

Mr. Frazier, chief pharmacist at Springfield City Hospital since 1938, received the award at a dinner meeting of the American Society of Hospital Pharmacists at the Los Angeles Athletic Club, April 21.

Established in 1949 by the Michigan Society of Hospital Pharmacists, the award honors the late Mr. Whitney, hospital pharmacy leader and founder of the A.S.H.P. Presentation was made by Clifton J. Latiolais, representing the Michigan chapter.

Mr. Frazier's lecture, titled "The Authority of Ideas," paid tribute to Mr. Whitney for his leadership in hospital pharmacy. Speaking of Mr. Whitney's contributions, he referred to the influence and inspiration which extended to many practitioners in the specialty as well as to the total profession. Further, the speaker said, Mr. Whitney possessed the "authority of ideas" resulting in the founding of the American Society of Hospital Pharmacists.

Mr. Frazier is a graduate of the Cincinnati College of Pharmacy; he is a charter member of the American Society of Hospital Pharmacists, and in 1952 served as president of this organization.

Robert Simons, chief pharmacist, Memorial Hospital, Wilmington, Del., was presented first prize in the hospital and clinic division of the American Pharmaceutical Association National Pharmacy Week competition. A plaque was presented to Mr. Simons for his Pharmacy Week hospital display at the first general session of the American Pharmaceutical Association. Second prize in this classification went to Sister Mary Oswalda, chief pharmacist, St. Joseph's Children's and Maternity Hospital, Scranton, Pa., and third prize was awarded to J. Sbihra Jr., Perth Amboy General Hospital, Perth Amboy, N. J.

Some 20 resolutions dealing with professional problems were passed at the final session of the annual meeting. Significant was a resolution spelling out the relationship of the chief pharmacist in academic centers where responsibility is sometimes divided between the dean of the college of pharmacy and the administrator of the hospital. The society took a logical course of action and recommended that the chief pharmacist be responsible to the administrative officer of the hospital for all service functions

Grover C. Bowles Jr. has been appointed contributing editor for pharmacy service of The Modern Hospital, *effective with this issue of the magazine. Mr. Bowles is director of the department of pharmacy at Baptist Memorial Hospital, Memphis. A graduate of the University of Tennessee School of Pharmacy, he served in the hospital corps of the U.S. Navy during World War II. Following an internship in hospital pharmacy at the University of Michigan Hospital, Mr. Bowles was a member of the faculty at the University of Tennessee School of Pharmacy. For five years, he was chief pharmacist at Strong Memorial Hospital and instructor in pharmacology at the University of Rochester School of Medicine and Dentistry, Rochester, N.Y. Before accepting his present appointment, Mr. Bowles was associate administrator of paramedical services, Memorial Hospital Association of Kentucky. He is a past president of the American Society of Hospital Pharmacists.*

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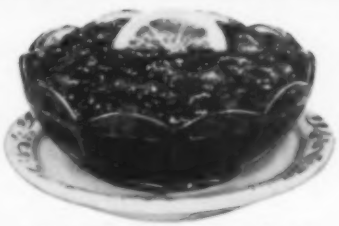
Campbell's Soup is good summer eating. It's the one hot dish your patrons and patients ask for all summer long.



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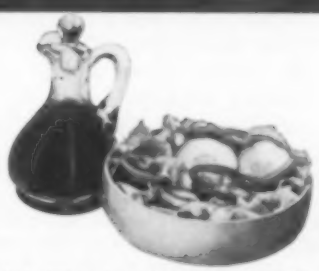

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RESTAURANT DIVISION (DEPT. B-61), CAMDEN 1, NEW JERSEY

of the pharmacy and to the dean of the college of pharmacy for all educational activities for which course credit is given by the college of pharmacy.

Another resolution set the works in motion for implementing the accreditation program for hospital pharmacy internships. Accreditation of pharmacy internships will be based upon the minimum standard for pharmacy internships in hospitals compiled by the A.S.H.P. Other resolutions provided for a complete revision of the society's constitution and by-laws and a long-range plan for revision of the minimum standard for pharmacies in hospitals.

Dr. Robert P. Fischelis, Washington, D.C., and M. R. Kneifl, St. Louis, were elected to honorary membership for outstanding services to hospital pharmacy. Mr. Kneifl is the executive secretary of the Catholic Hospital Association and managing editor of *Hospital Progress*. Dr. Fischelis is secretary and general manager of the American Pharmaceutical Association, the oldest national pharmaceutical association in the United States. Both are long-term friends of hospital pharmacy.

Robert C. Bogash, director of pharmacy service, Lenox Hill Hospital, New York, was installed as president of the organization. New vice president is Clifton J. Latiolais, University Hospital, Ann Arbor, Mich. Other officers are: Gloria N. Francke, Ann Arbor, Mich., secretary, and Sister Mary Berenice, St. Louis, treasurer of the society.

Nominations for office, with mail ballot election and installation at next year's convention are: For president, Dr. William M. Heller, Little Rock, Ark., and Jack S. Heard, Los Angeles; for vice president, R. David Anderson, Staunton, Va., and Vernon O. Trygstad, Rockville, Md.; for treasurer, Sister Mary Berenice, St. Louis, and Sister Mary Gonzales, Pittsburgh. #

Staph Epidemic Ends When Carrier is Found

When studies revealed the sources of this hospital infection, personnel assignment and technics were changed to curtail spread

F. Robert Fekety, M.D.
Elmer L. Shaffer, Ph.D.
Leon Buchbinder, Ph.D.
H. Preston Price, M.D.
Sidney Goldberg
Louis A. Pyle, M.D.

THIS report describes an epidemic of staphylococcal disease affecting infants and mothers at the Valley Hospital in Ridgewood, N.J., from February to June 1957. Thirty-three (10 per cent) of the 319 live births at the hospital during the epidemic were complicated by suppurative illnesses.

Excluding carriers of the epidemic strain from the nursery and changing certain nursery procedures and technics temporarily controlled the epidemic. Despite the continuation of these measures, a second outbreak occurred. It ended when a carrier of the strain was found and was excluded from further contact with the infants.

The Valley Hospital is a modern, attractive 118 bed general hospital; an average of 120 deliveries is performed there each month. The nursery consists of three connecting rooms with a capacity of 28 full-term infants in partitioned cubicles; it provides a minimum of 24 square feet of space for each infant. Additional rooms are provided for premature infants, isolation, examinations, formula preparation, utility procedures, and as workrooms for doctors and nurses. The entire nursery is on one floor and is adjacent to the maternity unit. Prior to this study, air was supplied by a partial-recirculation air conditioner equipped with filters and an ultraviolet light.

EPIDEMIC BACKGROUND

Suppurative disease in infants and mothers was first noted in the latter part of 1955, whereupon isolation and aseptic technics were revised. Nursery linen was autoclaved, frequent hand-washing with hexachlorophene soap was required, individual bassinet technics were adopted, gown and mask technics were improved, and the nursery policy book was revised. A decline in the incidence of illness was subsequently noted.

Pustular infections were noted again in September 1956. Despite the daily bathing of infants with hexachlorophene soap, suppurative illnesses were diagnosed in the nursery nearly once each week. In November, two infants born at the Valley Hospital died of staphylococcal pneumonia in other hospitals. Prompted by Shaffer's report[27] that the majority of such hospital acquired newborn illnesses began after discharge, the staff contacted local physicians and learned of other cases of empyema, pneumonia, breast abscess, and pyoderma. It was estimated that 10 per cent of all deliveries in November were complicated by suppurative disease in either infant or mother.

A trial of prophylactic erythromycin was begun in December 1956. As recommended by Shaffer,[27] erythromycin (44 mg/kg daily in six divided doses) was administered to

Dr. Fekety is a member of the Epidemic Intelligence Service, Communicable Disease Center, Public Health Service, U. S. Department of Health, Education, and Welfare, Atlanta, Ga., and is assigned to the Biological Division, Department of Medicine, Johns Hopkins University School of Medicine, Baltimore. Dr. Shaffer is director, Division of Laboratories, State Department of Health, Trenton, N. J. Dr. Buchbinder is assistant director and Mr. Goldberg is assistant bacteriologist, Bureau of Laboratories, New York City Health Department. Dr. Price is the pathologist and Dr. Pyle is an attending pediatrician, Valley Hospital, Ridgewood, N. J.

Presented at the American Public Health Association, Cleveland, 1957, and published originally in the American Journal of Public Health.

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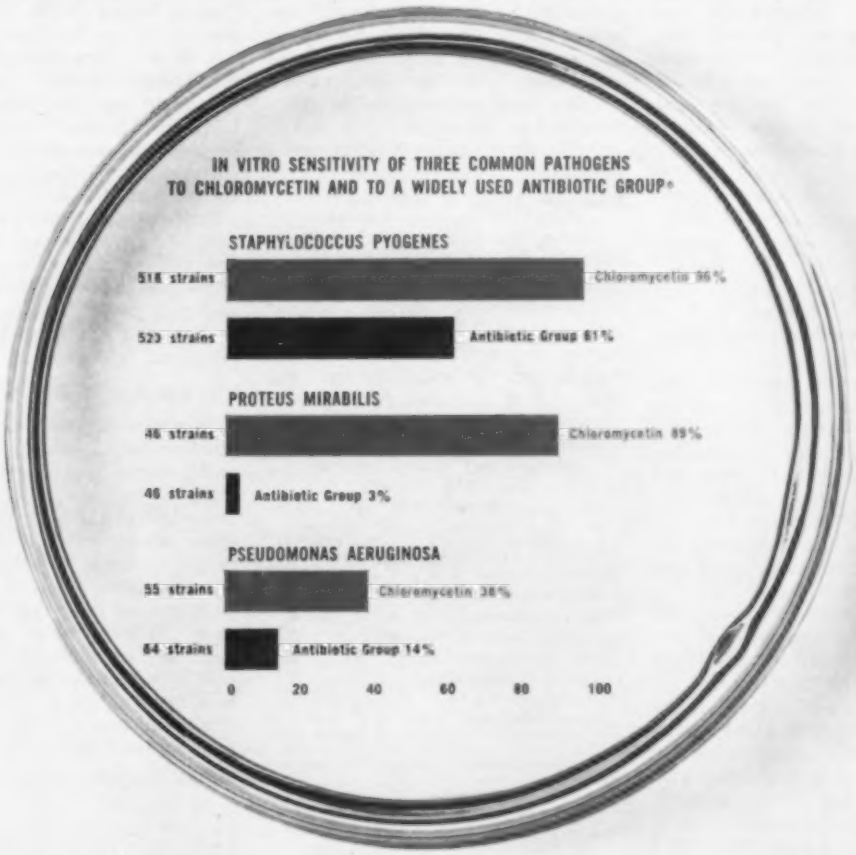

*Adapted from Roy, T. E.; Collins, A. M.; Craig, G., & Duncan, I. B. R.: *Canad. M. A. J.* 77:844 (Nov. 1) 1957.

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

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all infants beginning immediately after birth and was continued for seven days. Infants were discharged on the fourth postpartum day. Nursery personnel was advised to take oral erythromycin during this period. A sharp reduction in the number of clinical infections in the nursery was noted for about two weeks, but home infections were still reported. When 11 infants developed diarrhea on the foregoing regimen, the dosage of erythromycin was reduced to 35-40 mg/kg daily. Hexachlorophene bathing was discontinued at the same time for other reasons. Subsequently, four infants receiving erythromycin developed pyoderma while in the nursery, and another developed a breast abscess. In addition, erythromycin-resistant staphylococci were obtained from two asymptomatic infants. Despite the fact that the infant population was being treated with erythromycin, these organisms (later shown to have the bacteriophage pattern 52/42B/80/81) did not become established in the nursery, as they might have been expected to do if staphylococci were being transmitted from infant to infant.

When it became apparent that erythromycin had not eradicated the strain from the nursery, its use was discontinued, and the hospital requested assistance from the New Jersey State Department of Health. The present study was begun in February 1957, as a cooperative effort of the Valley Hospital staff, the New Jersey State Department of Health, the Bureau of Laboratories of the New York City Health Department, and the Communicable Disease Center of the U.S. Public Health Service.

Closing the nursery was considered at the beginning of this investigation, and was rejected because it has not been shown to be a permanent solution to this problem. Since the application of many generally recommended control measures had failed to check the epidemic, the authors felt that a period of study aimed at defining the sources of the causative agent and estimating the magnitude of the problem should be the basis for further control measures.

METHODS

Sterile cotton swabs were used to culture the anterior nares of all infants at the time of discharge from the hospital. A culture from the skin near the umbilicus was usually obtained at the same time. Chapman Stone agar (Difco) was used for the primary isolation of staphylococci which were then tested for coagulase production by the tube method, and for antibiotic sensitivity by the disk method. Staphylococci were typed by the bacteriophage methods described by Williams and Rippon,[21] and Blair and Carr,[4] as modified by Goldberg.[11] All lesions were cultured on blood agar. Cultures were obtained weekly from the anterior nares of all personnel with regular assignments to the nursery or delivery room.

Two methods were used to detect illnesses which began after discharge. The physician caring for the infant was questioned by telephone approximately six weeks after discharge about the health of the infant. Approximately half of the mothers were questioned by telephone approximately six weeks after discharge, about the occurrence of suppurative illness in themselves or their infants. The technics used were similar to those described by Ravenholt.[22, 23]

RESULTS

Rate and Types of Infection

During the entire period of study (February to August 1957) 844 live births were recorded and 34 suppurative illnesses were observed. Ten per cent of the 319 deliveries performed during the epidemic periods were complicated by staphylococcal disease. Table 1 shows the types of staphylococcal disease associated with this nursery over a one-year period.* Sixty-five suppurative illnesses were observed; 80 per cent of these occurred in infants. Fifty-three illnesses in infants were diagnosed; pyoderma was the most common disease manifestation. Eight infants and seven mothers developed breast infections. The majority of these mothers had breast fed their infants. Five infants developed pneumonia, empyema, or septicemia with internal abscesses, and only one of these infants survived. As shown in Figure 1 infant illnesses began on the ninth or tenth day of life on the average (median 5.5 days). Approximately half of the infections were diagnosed before the infant was discharged from the hospital. Maternal breast infections began on an average of 22 days postpartum. These observations are consistent with those of Wysham and others suggesting that puerperal mastitis is frequently due to organisms acquired in the nursery and transmitted by infants to their mothers, and that breast feeding appears to predispose the mother to this complication.[25, 27, 28, 33]

Table 1—Staphylococcal Disease in Mothers and Infants September 1956 Through August 1957

Illness	*Number*
Infant pyoderma*	36
Infant breast abscesses	8
Infant pneumonia, empyeme	4
Septicemia, internal abscesses	1
Deaths (due to the above)	4
Maternal skin infections	5
Maternal mastitis, breast abscesses	7

*Includes pustules, furunceles, abscesses, bullous impetigo, etc.

*September 1956 through August 1957.

The Etiologic Agent

Staphylococci obtained from 28 suppurative lesions which had their onset in the nursery were typed, and 25 of them (89 per cent) had the bacteriophage pattern 52/42B/80/81 (hereafter referred to as the epidemic strain, or strain 52/42B/80/81). The organism was hemolytic, coagulase-positive, and produced a yellow pigment. It was resistant to penicillin, streptomycin, and the tetracyclines, and was sensitive to chloromycetin, erythromycin, and novobiocin. A strain which is probably identical to this one has recently been implicated

Fig. 1—Time of onset of infant staphylococcal infections

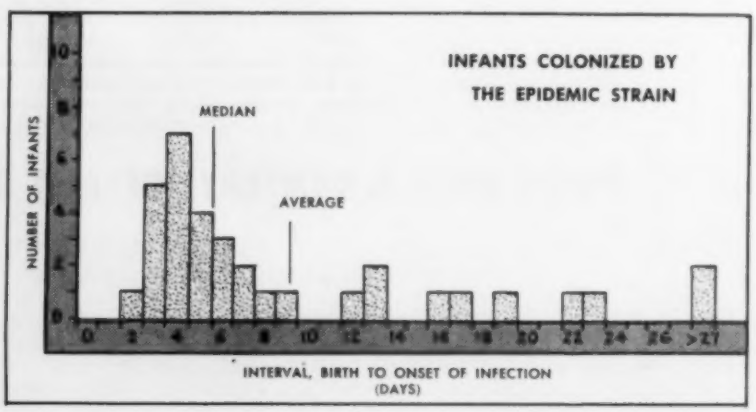

Table 2—Illness Rate Following Colonization of Infants by Two Kinds of Staphylococci—Feb. 21 to Aug. 21, 1957

	Staphylococcus Colonized	
	Strain 52/42B/80/81	Other Coagulase-Positive Staphylococci
Number of infants colonized (nursery)	49	92
Number of clinical infections which began in the nursery	17	1
Number of clinical infections which began at home	17	2
Number developing clinical infections	34	3
Per cent developing clinical infections	70%	3%

as the cause of more than 40 similar epidemics in the United States, Canada, Australia, New Zealand, and Germany.[37]

As shown in Table 2, 49 infants were colonized in the hospital by the epidemic strain; 17 of them (35 per cent) developed a suppurative illness due to the organism while in the hospital, and 17 additional infants (35 per cent) developed clinical infections at home. In all, 70 per cent of the infants colonized by the strain eventually developed disease. In comparison, 92 infants were colonized by other coagulase-positive staphylococci, and only three of them (3.3 per cent) developed lesions during the same period of observation.

Infants—Coagulase-positive staphylococci were obtained at the time of discharge on the third or fourth postpartum day from 141 (17 per cent) of the 844 infants born during this study. During the first seven weeks of this study 32 infants in the nursery (15 per cent) were colonized by the epidemic strain; 12 developed pustular disease prior to discharge and were transferred to isolation facilities. Colonized or clinically infected infants were present in the nursery throughout this interval, and transmission of the organism from one infant to another could not be ruled out as a means of perpetuation of the epidemic.

Sources of the Epidemic Strain

Mothers—Many investigators have stressed the lack of similarity between the strains of staphylococci carried by mothers on admission to the hospital and the strains acquired by their infants in the early postpartum period.[1, 5, 6, 12, 14, 19, 20] When a woman afflicted with an abscess caused by the epidemic strain was admitted to the obstetrical service, we were prompted to reconsider mothers as sources of the epidemic strain. Nasal cultures were obtained from 157 mothers at the time of admission to the hospital. Forty-one (26 per cent) carried coagulase-positive staphylococci, and two (1.3 per cent) carried the epidemic strain. One of the maternal carriers gave a history which suggested that she had acquired the epidemic strain during a prior hospitalization on the obstetrical service. Two infants (1 per cent of all infants, or 8 per cent of the infants colonized by staphylococci) acquired strains which were identical to their mothers' admission strains. Neither of these was the epidemic strain. The transmission of staphylococci from one mother to the infant of another was not demonstrable.

The Environment—Approximately 150 cultures were obtained from walls, floors, cotton blankets, bassinets, resuscitators, tracheal catheters, doorknobs, sink handles, air conditioner vents and filters, and so on, by means

Barnstead Briefs

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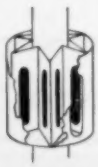

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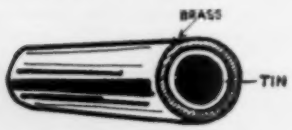
A crucial problem in the use of distilled water develops from the time it is received from the Water Still to actual usage. To prevent this metallic contamination, Barnstead has developed a complete line of pipe and fittings including draw-off valves. Although only freshly distilled water is used in intravenous work, such a distilled water distribution system can provide distilled water in convenient locations for many hospital uses, thereby saving time and money.



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All Barnstead Type "Q" Hospital Stills are equipped with a "bleeder valve" which continuously deconcentrates impurities within the evaporator. Where the raw water is high in bicarbonates, however, this bleeder valve should be closed. Bicarbonates tend to precipitate out of solution at temperature exceeding 150°F. More frequent draining and cleaning of the evaporator is required when the bleeder valve is closed.

FIELD REPORTS

Barnstead's new Ultra Violet Tank has undergone numerous tests to prove its effectiveness. Latest report from the research laboratories of Skinner & Sherman, Inc., Boston, include the following statement: "The ultra violet light will kill spore-forming organisms that might accidently be introduced into the tank . . . within two hours. In addition to these tests, we held distilled water in the tank with ultra violet light on for a 30-day period and examination of the water showed the material to be sterile."

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The late Admiral Richard E. Byrd, Antarctic explorer and scientist, on both of his first two trips to the South Pole brought along Barnstead Water Stills. They were indispensable for medicinal purposes, for battery water, and as a source of drinking water.

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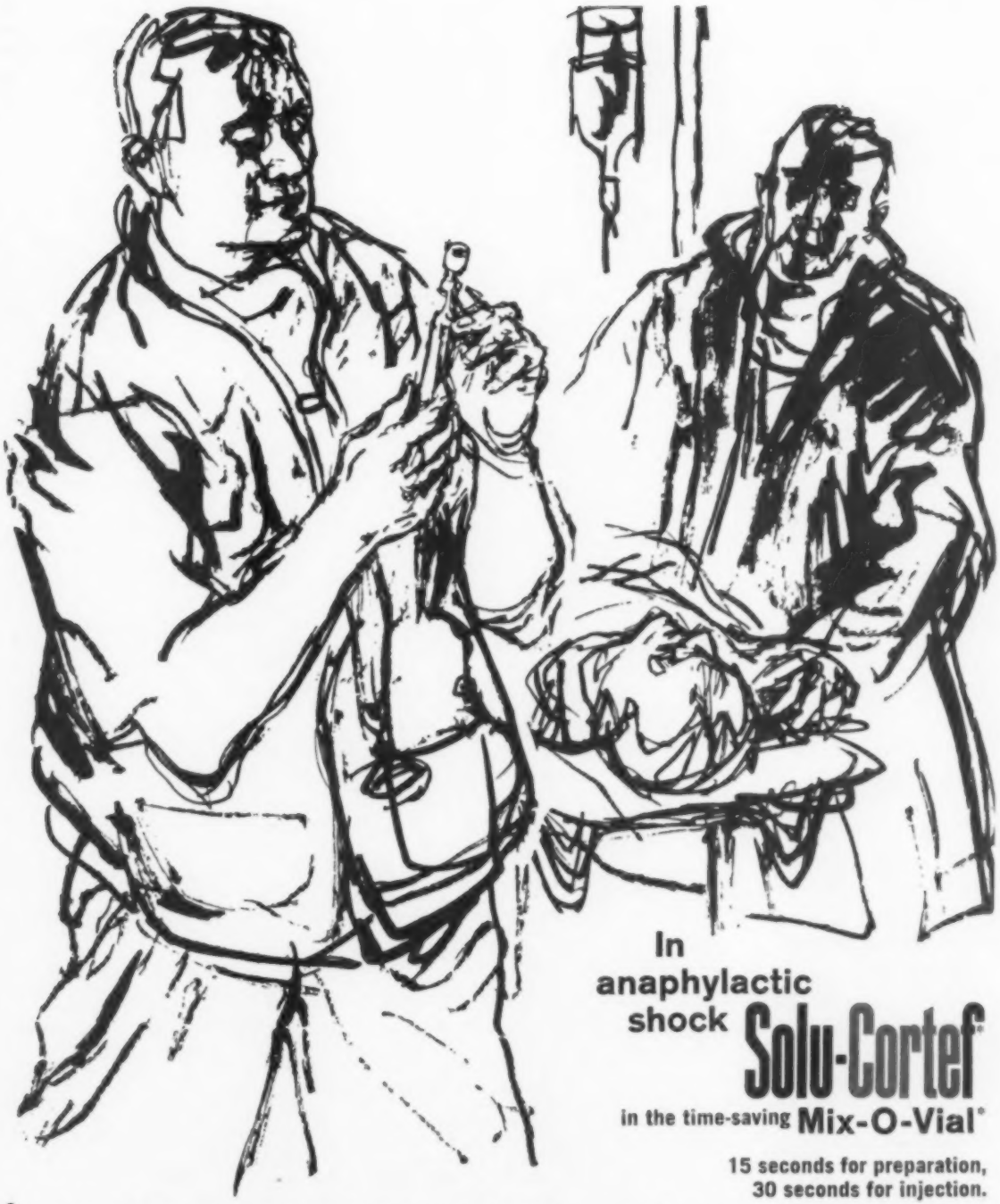
of moist cotton swabs. Staphylococci of the epidemic strain were isolated from three dust samples and from the blanket of an infant colonized by the epidemic strain.

Air—Blood and Chapman Stone agar settling plates were exposed to the air for one hour in various parts of the nursery on two occasions when nursery activity was maximal. Although a plentiful growth of bacteria was observed on them, only one of 60 settling plates yielded staphylococci of the epidemic strain. That plate had been exposed in the isolation room next to the bassinet of an infant with a pustular infection.

Nurses—Approximately 700 nasal cultures were obtained during this investigation from nurses, aides and porters who had regular duties in the nursery or delivery room. Coagulase-positive staphylococci were isolated on one or more occasions from the anterior nares of about three-fourths of the persons studied, although only about 40 per cent of the individuals cultured during any one week carried them. A few persons never carried staphylococci. Others carried a strain for brief periods only (transient carrier); and the same strain was repeatedly isolated from certain individuals (permanent carrier). A person who harbored the epidemic strain on two occasions was considered a permanent carrier until proved otherwise. Five persons working in close contact with infants were found to be asymptomatic permanent carriers of the epidemic strain during the first seven weeks of this study. When these individuals were later excluded from the nursery they did not rapidly lose the strain. We could not isolate the epidemic strain from the hands of permanent nasal carriers who washed their hands with hexachlorophene soap.

Evidence that nurses are important sources of the organisms acquired by infants was obtained by analysis of the strains prevalent in the nursery during interepidemic periods. Coagulase-positive staphylococci were acquired by 92 infants during these periods; 62 isolates (67 per cent) were typable. Several nurses who were carriers of nontypable strains were assigned to the nursery, and were possible sources of the nontypable strains. Of the 62 typable isolates, 51 (82 per cent) were identical with the strains of permanent carriers working in the nursery when the organisms were isolated from infants. Some of the infant strains which could not be traced to nursery personnel were traced to mothers.

The epidemic strain was the only strain which was prevalent in the nursery for prolonged periods. It was frequently observed that a strain



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References: 1. Hull, E.: Kansas City M.J. 33:19 (March) 1957. 2. Grater, W. C.: Ann. Allergy 13:191 (March-April) 1955. *Trademark, Reg. U. S. Pat. Off.

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which was predominant in the cultures obtained from infants in one week was entirely absent from the nursery in subsequent weeks. There was no tendency for a strain to localize in one room, which suggested that air-borne spread was not frequent.

Doctors—We did not undertake an intensive cultural study of doctors. During a period when 17 infants were colonized by the epidemic strain, the outbreak could not be related to any single doctor. None had cared for more than five of the affected infants.

Other Parts of the Hospital—Children on the pediatric ward were occasionally infected with the epidemic strain. It seemed likely that personnel carriers of the epidemic strain were working on the pediatric ward, even though some of these illnesses were acquired outside the hospital.

Staphylococci were isolated from 71 outpatients at the hospital (Table 3). The majority of these isolations (59 per cent) were the epidemic strain, and were related to a recent contact with hospitals. Infants born at the hospital and their close relatives returned for treatment of suppurative illnesses due to the epidemic strain. Nine infants who were born at other hospitals in New Jersey were treated for disease caused by the epidemic strain. Five persons without any hospital contact in the recent past presented with infections due to the epidemic strain, but most persons with no prior contact with hospitals yielded staphylococci which were not the epidemic strain.

Since the methods of transmission of the epidemic strain were not defined by the cultural studies described here, the relative importance of personnel carriers and the infant reservoir in the perpetuation of an epidemic could not be ascertained. Control measures were therefore aimed at preventing the spread of staphylococci from both groups.

Control Measures

Nursery employes who were permanent carriers of the epidemic strain were assigned to other parts of the hospital. Assignments with minimal patient contact were chosen for them.

Other measures were aimed at preventing the transmission of staphylococci from infant to infant. It has been shown that infants who are more than three days old are particularly likely to be carriers of staphylococci.[7, 28, 29] Therefore, the hospital began to discharge infants and mothers on the third postpartum day. If complications prevented early discharge, the infant was transferred to other facilities.

As a result, it became possible to utilize the three nurseries as separate units, and to segregate infants by date of birth (although the nursing staff was common to all of them). All infants were admitted to one room until it was full or until 48 hours had elapsed, at which time the room was closed to further admissions. In this way, infants were directly exposed only to others of approximately the same age. When all newborns had been discharged from a nursery, it was cleaned, washed with a disinfectant, and aired until it was again needed (usually 24 hours).

(*Continued on Next Page*)

Table 3—Sources of Coagulase-Positive Staphylococci Isolated From Outpatients at the Valley Hospital—Feb. 21 to Aug. 21, 1957

Source of Culture	Staphylococci Isolated	
	Phage Type 52/42B/80/81	Other Phage Types
A. From Clinical Infections:		
Suppurative lesions in infants born at the Valley Hospital (onset after discharge from the hospital)	16	3
Suppurative lesions in close relatives of infants born at the Valley Hospital	3	0
Suppurative lesions in infants born at other hospitals	9	0
Suppurative lesions in persons with no known recent hospital contact prior to the onset of their illness	5	15
B. From Nose, Throat, or Skin Cultures:		
Asymptomatic close relatives of infants born at the Valley Hospital	9	0
Routine cultures from persons with no known recent hospital contact prior to the onset of their (nonsuppurative) illness	0	11
Total	42	29

PIGMENTED VILLONODULAR SYNOVITIS
. . . 3 aspects

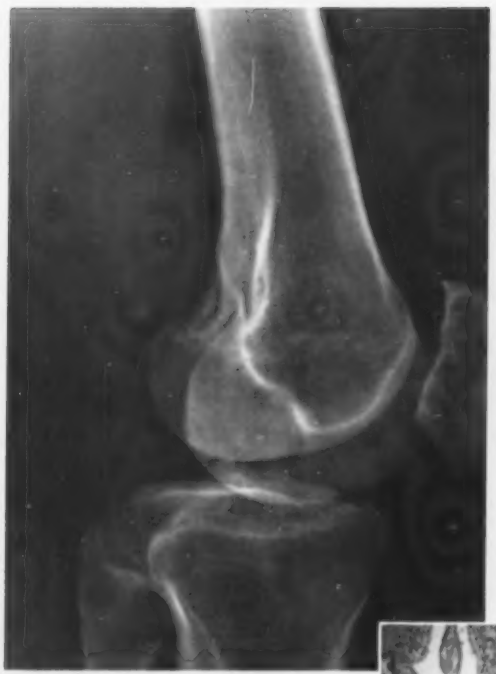

Figure 2 *(above)*—Photograph of a portion of the resected synovium with attached menisci from the case shown in Figure 1. Note the deep brownish color of parts of the villously hypertrophied synovium.

Figure 1 *(above)*—Lateral radiograph of knee area in a case of pigmented villonodular synovitis in a man of 53 years. Note the lobulated soft-tissue masses posteriorly and the effects of invasion of the patella and the femoral condyles by lesional tissue.

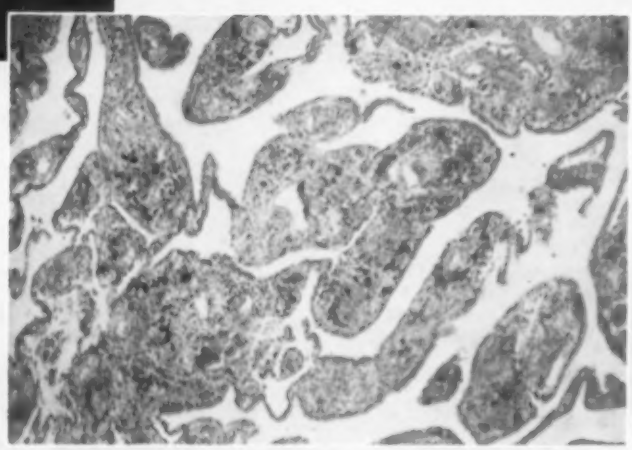

Figure 3 *(right)*—Photomicrograph (x 25) showing a tissue area in a villonodular synovitis in which the proliferated villi are matted together. The brownish discoloration of the tissue is due to hemosiderin pigment.

Turn page for data on Synovial Osteochondromatosis . . . 3 aspects

SYNOVIAL OSTEOCHONDROMATOSIS . . .
3 aspects

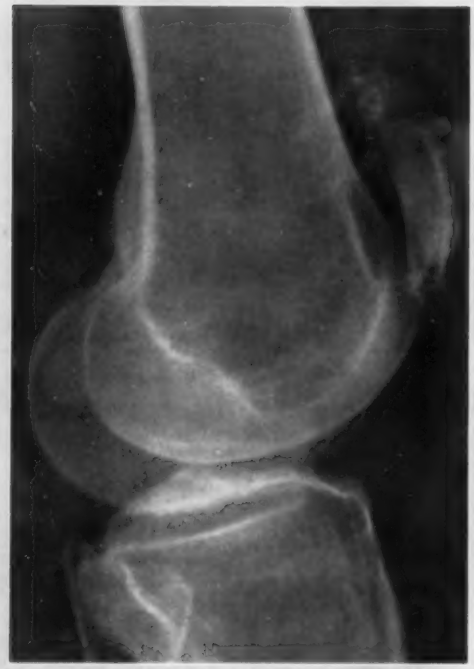

Figure 1 *(above)*—A lateral radiograph from a case of synovial osteochondromatosis of the knee. Note the faint opacities in the suprapatellar pouch area and in the posterior compartment.

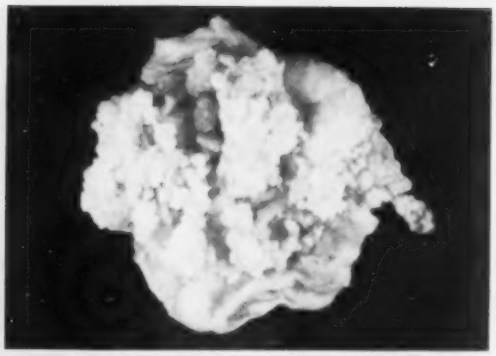

Figure 2 *(above)*—Photograph showing the synovial surface of the suprapatellar pouch. Note the cartilaginous excrescences, many of which are protruding from the surface.

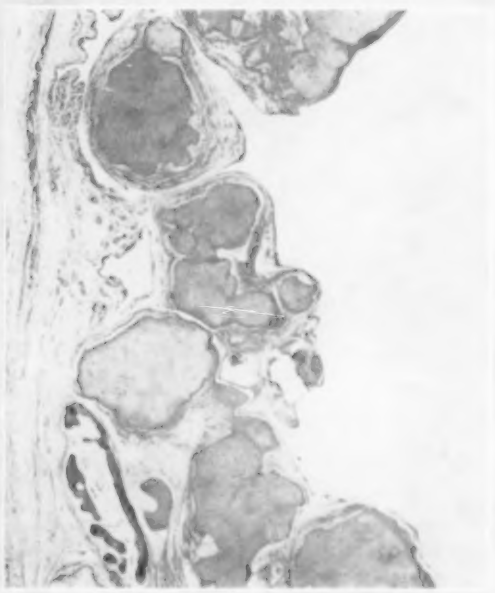

Figure 3 *(right)*—Photomicrograph (x 3) of representative section prepared from lesional tissue shown in Figure 2. Note the numerous islands of cartilage within the synovial membrane. Some are agglomerated and are protruding into the pouch.

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Always turn to HOSPITAL PURCHASING FILE when you choose any equipment or supplies—either familiar items or those you buy only occasionally—for detailed information to help you compare and select. Here, all in one place, are the catalogs of manufacturers who are most eager to help you make wise buying decisions. Catalogs are grouped by hospital departments and simply, accurately indexed to help you find what you are interested in easily and quickly. Keep Hospital Purchasing File on your desk. Be sure your department heads use it to speed up product comparison. Below is a list of catalogs of furniture and other equipment (CA) and floor maintenance equipment and supplies (CB).

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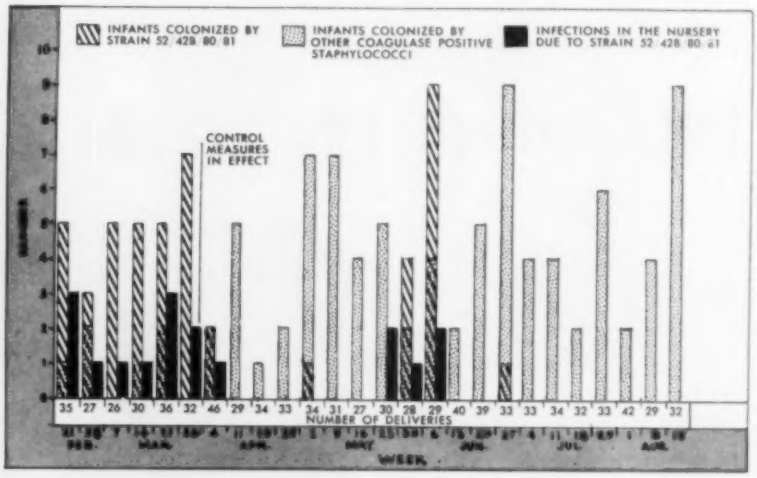
Fig. 2—The Colonization and Infection of Infants by Staphylococci Prior to Discharge From the Hospital Feb. 21 to Aug. 21, 1957



Finally, changes in aseptic technics and equipment were adopted. Most important, perhaps, was the change to wet-mopping and damp-dusting in the nursery (to the exclusion of vacuum cleaning, which has been shown to create air currents). The ventilating system was changed to one using 100 per cent outside air (no ultraviolet light was used). Improved hand-washing and foot-operated diaper disposal facilities were provided. Unauthorized personnel was barred from the nursery. Formulas were prepared by terminal sterilization at 212°F. for 25 minutes (as compared with 20 minutes previously). Careful hand-washing, between infants, with a hexachlorophene detergent was stressed. While all persons who were not assigned to the nursery were required to wear masks and gowns upon entering it, the nursery personnel was not required to wear masks.

Effect of Control Measures

Figure 2 shows the course of the epidemic during the 26 weeks of study. Only illnesses which began in the nursery and were caused by the epidemic strain are shown. Figure 2 also shows the number of isolations of coagulase-positive staphylococci and of strain 52/42B/80/81 that were obtained from the nursery each week.

Home follow-up showed that the incidence of disease in the nursery was a reliable index of the morbidity at home during this study (Table 4). When a high incidence

Table 4—Relation of the Rate of Colonization and Illness in the Hospital to the Rate of Illness at Home

	Epidemic Periods February 21-April 10 May 23-June 12		Inter-epidemic Periods April 11-May 22 June 13-August 21	
	Number	Per Cent of Deliveries	Number	Per Cent of Deliveries
Total deliveries	319		525	
Infants colonized by the epidemic strain in the hospital	47	15	2	0.4
Epidemic strain illnesses detected in the hospital	17	5	0	...
Epidemic strain illnesses detected by follow-up methods	16	5	1	0.2
Total illnesses due to the epidemic strain	33	10	1	0.2
Illnesses at home detected by follow-up methods (without regard to cultural proof)	57	18	14	2.7
Total illnesses in hospital and home	74	23	14	2.7

of disease was observed in the hospital, a high incidence after discharge was observed, and the converse was also true.

Two distinct epidemic waves were observed. The first has already been described; it occurred during the period from February 21 to March 28 when the initial epidemiologic investigations were performed. Most of the control measures were instituted during the latter part of March. By the week of March 28 all known carriers of the epidemic strain had been excluded from the nursery, and the early discharge of infants was begun. As shown in Figure 2, a marked reduction in the incidence of colonization and infection by the epidemic strain in the nursery was observed in the following seven weeks. Only one infant was colonized by the strain, and none developed illness in the nursery during the period from April 11 to May 22.

Despite these measures, however, a second outbreak was observed from May 23 to June 12. Fifteen (17 per cent) of 87 infants born then were colonized by the epidemic strain, and five infants (6 per cent) developed suppurative illnesses. During this outbreak the isolations of the epidemic strain were distributed in a random way through four nursery rooms. Airborne spread from infant to infant might have been expected to localize the isolations in one room during brief intervals. That they were not so localized suggested that air-borne transmission of the organism was infrequent.

Three possible explanations for the outbreak were obtained. The first isolation of the strain in the outbreak was from an infant delivered by cesarean section in the operating room. A nurse and an aide working there were found to be carriers of the epidemic strain. Two women who were carriers of the epidemic strain were admitted to the maternity unit shortly before this outbreak began. Neither of their infants acquired the strain while in the hospital. Finally, a part-time nursery worker, not previously cultured, was found to be a permanent carrier of the epidemic strain during the outbreak. The mothers and operating room personnel who were carriers had no direct contact with the infected infants, but the nursery worker did have contact with them. The outbreak terminated abruptly when she was assigned to another part of the hospital.

From July 1 to October 31 no infants in the nursery were colonized or infected by the epidemic strain (Fig. 2). Home follow-up confirmed that the epidemic was under control (Table 4). In addition, 117 infants

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born at the hospital from August 5 to September 8 were seen at home by members of the local Visiting Nurse Association approximately two weeks after discharge. Nasal cultures were obtained from infants and mothers. No illnesses due to the epidemic strain were detected. One mother and her infant were found to be carriers of the epidemic strain, but it did not appear that the strain had been acquired during their recent hospitalization.

As Figure 2 shows, the rate of colonization of infants by staphylococci of all types was not affected by the control measures instituted in March. Therefore, a strain specific control measure was probably responsible for the eradication of the epidemic strain from the nursery. The only measure affecting the epidemic strain exclusively was the removal of carriers of the strain from the nursery.

While staphylococcal infections of the newborn have been recognized for many years, they seem to have become more frequent within the past decade, and they now constitute a major public health problem.[20] Many observers have attributed the increase in the frequency of these infections to the widespread use of antibiotics, with the resultant emergence of antibiotic-resistant staphylococci, and the creation of hospital personnel and patient reservoirs of these organisms.[18, 20] A great deal of interest in the epidemiology of staphylococcal infections has been shown in the past few years as a result of the finding that staphylococci can be typed by means of bacteriophages.

There is ample evidence to support the belief that nurses are the most frequent sources of the staphylococci which colonize infants in nurseries under nonepidemic conditions. Allison and Hobbs,[1] Rountree,[20, 21] Webb,[20] McCartney and Yates,[20] Barber, et al.,[2] and Baldwin, et al.,[2] noted the high frequency with which the strains isolated from infants were present in personnel working in the nursery. However, it has been suggested that the colonization of the staff by a given strain may be the consequence rather than the cause of infant colonization by the same strain. Baldwin, et al.,[2] noted the frequency with which personnel carriers of strains which are prevalent in a nursery lose that strain when they are relieved of nursery duties. However, the same authors have demonstrated that the strains acquired by infants were commonly carried by nurses prior to the introduction of the strain into the infant population. Similar observations were made during the present study.

(*Continued on Next Page*)

The importance of personnel carriers in the perpetuation of an epidemic is uncertain. The assignment of a carrier of a given strain to a nursery has occasionally resulted in an outbreak of infections due to that strain (previously absent from the nursery).[1, 3, 6, 14, 25] Several outbreaks have been controlled by detecting and eliminating carriers.[1, 25, 15] The control of epidemics by the local antibiotic treatment of the personnel nasal carrier has been reported.[6, 24]

Others have assigned a minor rôle to the personnel carrier once the strain has been introduced into the nursery, and feel that transmission of the organism from infant to infant is of greater importance.[2, 6, 22, 20, 23] Epidemics have been controlled by measures which were not aimed at the elimination of personnel carriers.[6, 23] Wysham described an epidemic due to the 52/42B/81 strain in which no personnel carriers were detected.[23]

Jellard[17] implicated the infant's umbilicus in the spread of staphylococci. She observed a lower colonization rate in the nursery when an antiseptic solution was used in the care of the umbilical stump, which was likened to an infected wound. The hands of nursery personnel have been considered a likely carrier. Allison and Hobbs[1] were unable to detect any permanent hand-carriers in the absence of nasal carriage of the organism, but Jellard[17] found that transient hand-carriers of strains endemic to the nursery were common in spite of frequent hand-washing. Several investigators found that the use of sterile rubber gloves by nursery personnel had no effect on the course of an epidemic.[6, 20, 27] Bathing infants daily with hexachlorophene soap has apparently reduced the spread of staphylococci,[6, 12] presumably by prevenitng colonization of the skin and by reducing the frequency of transmission via hands and the air.

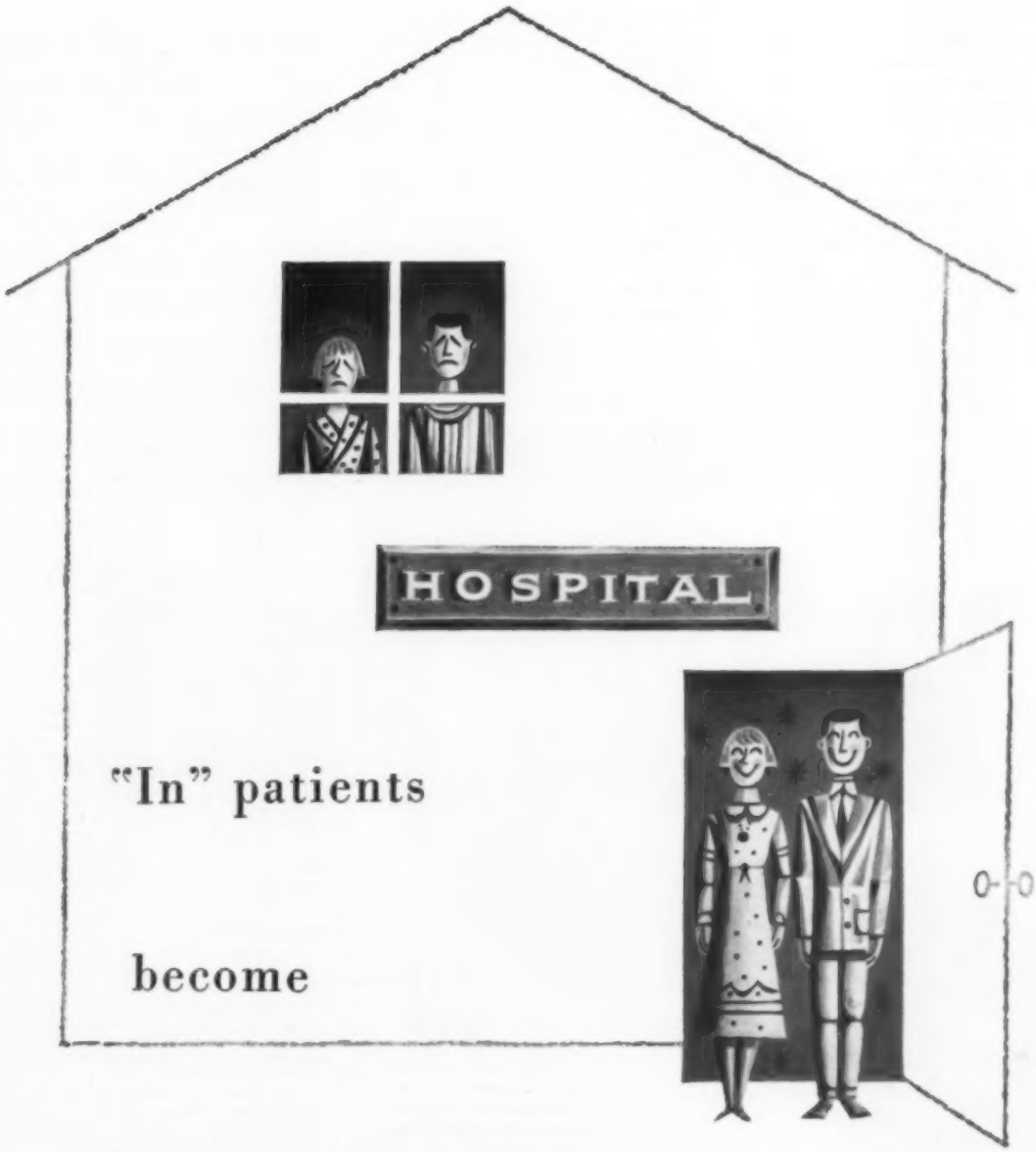
It is important to recognize that even if infant to infant transmission were of primary importance in an epidemic, there are a multiplicity of virtually unexplored ways in which it could be operative. Though staphylococci of the epidemic strain have been found in the air and dust of nurseries, a causal relation between the number of organisms and the incidence of infection has never been demonstrated. Perry, Siegel, and Rammelkamp[21] studied an analogous situation and found that group A streptococci recently deposited in dust by individuals harboring them during epidemics produced no infections when inoculated into the respiratory tract of presumably susceptible men. They concluded that simple survival of the organism in dust does not indicate that growth on the mucous membranes of suscep-

tible hosts will occur. Hare and Thomas[18] argued that the direct expulsion of staphylococci into the air in droplets or droplet nuclei from the anterior nares is less important than the indirect route involving egress in nasal secretions and the secondary contamination of skin, clothing, bedding and so on. This indirect mechanism would serve to emphasize the importance of mantaining strict aseptic and isolation technics in the nursery in order to prevent the spread of staphylococci from both infant and personnel carriers. It should not be assumed that the only solution to the problem of nursery staphylococcal infections lies in elaborate methods for the control of air-borne infectious agents. The available evidence suggests that more realistic and readily attainable practices will suffice to prevent hospital infections.

When the investigation reported here is viewed in relation to those discussed before, two general impressions concerning staphylococcal infections of the newborn stand out. The first is that infants in nurseries represent a population which is highly susceptible to epidemics of staphylococcal infections; that characteristic and unusual staphylococci are the principal offenders in this country at the present time, and that the strain may be introduced into the nursery in a multitude of ways. The fact that mothers infrequently transmit staphylococci to their infants while in the hospital loses some significance when it is realized that the epidemic strain can be isolated from persons in the general community, that it can be transmitted to an infant by its mother, and that an epidemic can probably be initiated by one infected infant. In addition, it appears that strain 52/42B/80/81 can be isolated from patients in all parts of hospitals,[8] and that nursery workers are frequently exposed to such patients or the staff caring for them. These facts have considerably increased the difficulty of preventing the introduction of the strain into a nursery.

Second, there are probably many ways in which an epidemic can be perpetuated in a nursery, and they are probably frequently operative in combination. Therefore, there is no single simple method of control which can be recommended for application to all epidemics.

It is not unlikely that one nurse carrier might be responsible for a prolonged outbreak if her contact with infants were of a sufficient nature and degree. A significant number of infants may be infected by a carrier who is easily overlooked. Baldwin, et al.,[2] reported such an instance. A strain that predominated in their nursery for a month was "finally traced to anes-



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thetist in the delivery room," and the strain disappeared from the nursery when she was transferred from the obstetrical service. The evidence strongly suggested that a similar situation was observed during the present study. From the work of Hare and Thomas,[12] it appears that certain asymptomatic carriers are more dangerous than others. A carrier with an overt infection is probably extremely dangerous, and it hardly seems necessary to emphasize the importance of excluding such persons from the nursery. Infant to infant spread via the air and dust might be particularly encouraged by overcrowding, inadequate ventilation, and poor housekeeping. Improper technics and certain kinds of skin or umbilical care might facilitate infant to infant transmission via fomites and hands. Infant to infant spread might operate by the production of personnel carriers (either permanent or transient) secondary to infant contact. Finally, it should be mentioned that the perpetuation of an epidemic might be dependent upon certain strain characteristics such as high infectivity, increased growth and surface-survival rates, or the ability to compete with other micro-organisms for host sites.

Nonetheless, the complexity of the situation does not signify that control is impossible. While the possibility must be entertained that the control of the epidemic reported here was a result of factors unrelated to the control measures instituted, temporal relations make this unlikely. Some of the measures instituted here are not applicable to all nurseries, and are not recommended for general adoption. However, the experience gained in the study of this epidemic has led the authors to conclude that it is possible to control and prevent nursery staphylococcal infections if personnel carriers of the epidemic strain are relieved of duties in the nursery and strict attention is given to commonly recommended policies of infant care and aseptic technics. Segregation and early discharge of infants are probably only adjunctive control measures which should not be adopted to the exclusion of more proved and direct measures to control the spread of infectious agents in a nursery.

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Selective Menus Needn't Mean Extra Work

Dietitians at this Veterans Administration hospital developed a five-week cycle of master selective menus, found that the patients were more satisfied with food. Savings on ration cost totaled about $20,000 per year.

Gladys B. Swenson

THE usual practice of menu writing in Veterans Administration hospitals has been to prepare a weekly menu of foods to be served to patients and employes. No choice of foods was given except that there was a selection of beverage and bread.

This method resulted in patient dissatisfaction as to the variety and quantity of food served. Consequently, there was a large amount of plate waste in food returned uneaten.

A method of using selective menus was developed recently for serving to patients and employes on regular diets and for serving to patients on modified diets.

The steps used are as follows:

A weekly "Master Selective Menu" (Fig. 1) was developed. This has the basic foods listed in the left column. Each of these foods has a number, which becomes a code for writing the modified diets.

A master selective menu is prepared for patients on regular diets and for employes.

Using this as a basis, another master selective menu is prepared for the low sodium and the bland diets, since these are prescribed for a large number of patients.

All foods on the regular menu which can be served on the modified diets are used. In writing the regular master menu, at least one food under each number is one that can be used for the modifications.

A series of five weeks of master menus is prepared. Each menu is given a series number from 1 through 5. At the end of five weeks the series is repeated.

A five-week cycle was selected because this covers a sufficient period of time to avoid any sense of monotonous repetition on the menu by the patient, yet is short enough to simplify ordering and planning of work in the kitchen.

All modified diets, whether selective or not, also rotate every five weeks. This has simplified diet writing for the dietitians and the time saved can be used for patient contact, teaching and other duties.

Food buying is also simplified because the order is repeated every five weeks. This permits more rapid and accurate calculation of the amounts of food required, as these calculations are based on past experience with regard to patients' food preferences.

COOKS KEEP WORK SHEET

The cooks' daily work sheet is kept after it is used until the next time the same menu appears five weeks later. Notations are made on it of problems, amounts of food actually required, and any other data the cooks who work from it think necessary. This modified work sheet is used as a guide for preparation of the new work sheet during the next cycle. This procedure saves time for the chief cook in preparing each work sheet. The repetition of a set meal during each five-week period makes it possible for the cooks to improve their efficiency in preparation.

A cycle menu makes it less difficult for the chief dietitian to stay within her budget and also permits her to match the ration pattern more exactly, since it reduces the fluctuation that results from varying menus more or less at random.

At the present time two sets of master menu cycles have been prepared, one for the summer months when many fresh fruits are available and the other for the rest of the year.

From master menu sheets the typist cuts stencils for the menu that the patient uses (Fig. 2, page 116). This

The selective menu system described by Miss Swenson, one of its originators, was recently adopted for use in all Veterans Administration hospitals. The dietitians at Veterans Hospital in Portland, Ore., where Miss Swenson is chief of the dietetic service, won an award from the V.A. for developing the system. Miss Swenson has been employed by the V.A. for 16 years. During World War II, she served as an army dietitian, including 19 months of duty at a general hospital in England. She received her bachelor's degree from the University of Minnesota.

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MASTER SELECTIVE MENU

WEEK OF:				
MENU ITEM	DAY ▶			
BREAKFAST				
1. FRUIT				
1A. JUICE				
1B.				
2. COOKED CEREAL				
2A. DRY CEREAL				
2B.				
3. MEAT				
3A.				
4. EGGS				
7A. VARIETY BREAD				
7. TOAST AND BUTTER	WHITE - WHEAT	WHITE - WHEAT	WHITE - WHEAT	WHITE - WHE
7B. JELLY - JAM				
NOON				
1. SOUP - CRACKERS				
1A.				
1B.				
2. MEAT				
2A.				
2B.				
2C.				
4. POTATO				
4A.				
5. VEGETABLE				
5A.				
5B.				
6. SALAD OR RELISH				
6A. SALAD DRESSING				
6B.				
6C.				
7A. VARIETY BREAD				
7. BREAD AND BUTTER	WHITE - WHEAT	WHITE - WHEAT	WHITE - WHEAT	W
8. DESSERT				
8A.				
8B. FRUIT				
8C.				

Fig. 1, above: One of the weekly master selective menus. Basic foods are listed in left column; numbers become a code for writing the modified diets. Another master menu is prepared for patients who have low sodium and bland diets.

menu is designed for ease in tabulating. The patient checks the items he desires in a column at the left of the menu. He may put in numbers if he desires, such as 2 slices of whole wheat bread. All items that are tallied are in the left column; some items, such as milk and cream, are not tallied. Having all tallied items in the left column permits aligning as many as 10 menus at a time for tallying, which speeds up this process. Tally totals are noted on a copy of the menu; this becomes a part of the cooks' work sheet.

White paper is used for regular diets, yellow for low sodium, and green for bland. Colors make it simple to sort menus for tallying and also increase accuracy in distribution of menus to patients.

The menu for the following day is sent to the patient on his breakfast tray. He makes his selection and leaves the menu on his tray. The attendant who collects the tray puts the menu in a pocket attached to the food cart in our general medical and surgical hospital, which has centralized food service.

In the decentralized tuberculosis service, the menu is returned to the ward serving unit.

The entire day's menu is tallied at one time. These menus are then cut into the three meals of the day and the pack of menus is returned to each ward nurse at the time nourishments are taken to the ward. The nurse keeps these menus as she would patients' diet cards.

As new patients are admitted, the nurse adds the appropriate diet card. At the first breakfast the patient is served, he receives the menu for the following day. No attempt is made to give a new patient a selective menu until the menus are routinely distributed. A new patient on a modified diet is visited and instructed by a dietitian before he makes his selection from the menu. This assures prompt attention from a dietitian and is the beginning of the patient's instruction about his diet. A selective menu is a valuable teaching aid.

The menu which the patient has checked is reviewed by a dietitian. This is done quickly by scanning. Any inadequate or odd selection of food is readily spotted and the patient who makes such selections is visited by a dietitian on her next rounds.

Some patients are unable or do not desire to select food; these remain on diet cards. The first item in each group from the selective menu is served to them.

The selective modified diets are identified by the series number and the day of the week only. This makes it possible to cut and run one stencil for several rotations of the menu, saving time for the typist and for the mimeograph room. This is practical where a comparatively small number of copies is required. It is not practical for the regular menu; the stencil wears out after about 300 copies.

Advantages of the selective menu method include the satisfaction of the patient—complaints about food have almost reached the vanishing point—and reduced ration cost.

The reduction in costs is the result of less plate waste. Foods not desired by the patient are not served to him. During a three-month period previous to use of the selective menu the ration cost was $1.1798. During the same three months a year later, with the selective menu, the cost was $1.0129 per ration. The menu in each period was similar. The fluctuation of food prices was between 1 per cent and 2 per cent.

Conservatively estimating a 10 cent saving per ration as attributable to using a selective menu, the saving on 200,000 rations served in a year is $20,000.

It is estimated that approximately an additional eight hours per week was spent by dietitians writing menus before a rotation or cycle menu was introduced. This time is now being used for more patient contact, an improved teaching program for employes, and supervisory duties.

No additional employes have been required to implement this method. Careful planning of the menus obviates need of preparing items in addi-

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tion to the foods normally prepared. The amounts of food prepared have changed but not the number of items offered.

Before a selective menu was used a list was kept of foods which long-term patients would not eat. When these items appeared on the menu, substitutions were necessary. Keeping the lists took time and preparation of special orders took time. With a selective menu no lists need to be kept. No special orders are required.

Time is saved in serving because employes do not have to read a diet card with write-ins of likes and dislikes. Checks on menus require no study to interpret. Accuracy is increased.

Since it is necessary to write menus for only 70 days a year plus holidays such as Christmas, Thanksgiving and the Fourth of July, instead of menus for 365 days, there is more time to do a good job.

Nutritive value, of course, is considered, but there is also time to consider color, texture and garnishes.

It is possible to have recipes that are standardized in line with the amounts actually required at this hospital. Cooks now take more interest in improving recipes and preparation procedures; whether this is because they have more time, or because they realize this same problem will appear again in five weeks and therefore deserves immediate attention, is not known.

The selective menu is a valuable teaching aid. Patients on modified selective diets become acquainted with selection of foods permitted them during their hospital stay. Teaching is not left until the day the patient is ready for discharge. Patients on regular diets who have poor food habits can be readily noted because of their selections of food and instructed in improving their food intake.

It is possible to use foods on a selective diet that are not acceptable to all patients. Examples are: lamb, chow mein, chili beans, sardines. We have found that foods which were generally unpopular on a straight menu are now selected by a certain number of patients.

Those who helped in the development of the selective menu plan included: Miss Olive Carlson, assistant chief; Miss Alice Becker and Mrs. Gloria Jorgenson, supervisory dietitians at the Portland hospital; Miss Estelle Jamison, now assistant chief dietitian at the Vancouver Veterans Hospital, and Miss Jo Mercer, now assistant chief dietitian at the Denver Veterans Hospital. The latter two were stationed at Portland at the time the plan was devised. #

GENERAL DIET

NAME _____ WARD _____ ROOM _____

Breakfast — Thursday, March 6

_____ Tomato juice
_____ Orange juice

_____ Oatmeal
_____ Dry cereal
_____ Bacon
_____ Soft cooked egg
_____ Scrambled egg
_____ Fried egg

_____ Whole wheat toast
_____ White toast
_____ Jelly _____ Butter
_____ Coffee _____ Milk _____ Tea
_____ Cocoa _____ Sugar _____ Cream

NAME _____ WARD _____ ROOM _____

Dinner — Thursday, March 6

_____ Cream pea soup—crackers

_____ Grilled liver-creole sauce
_____ Scrambled eggs

_____ Mashed potatoes
_____ Creamed potatoes

_____ Cauliflower au gratin
_____ Lyonnaise carrots

_____ Arabian peach salad
_____ Coleslaw

_____ Whole wheat bread
_____ White bread
_____ Butter

_____ Chocolate éclair
_____ Vanilla pudding
_____ Royal Anne cherries

_____ Coffee _____ Milk _____ Tea
_____ Cocoa _____ Sugar _____ Cream

NAME _____ WARD _____ ROOM _____

Supper — Thursday, March 6

_____ Cream spinach soup—crackers

_____ Swiss steak
_____ Grilled lamb chop

_____ Parsley buttered potatoes
_____ Steamed rice

_____ Baked squash
_____ Buttered asparagus

_____ Tossed green salad
_____ Garlic dressing
_____ Pear jelly salad

_____ Whole wheat bread
_____ White bread
_____ Butter

_____ Maple mold—nut fluff topping
_____ Fruit cocktail

_____ Coffee _____ Milk _____ Tea
_____ Cocoa _____ Sugar _____ Cream

Fig. 2, above: Menus presented daily to each patient, who checks items he desires. White paper is used for the regular diets, yellow for low sodium, and green for bland. Colors make it simple to sort the menus for tallying.

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Small Hospital Finds Nonselective Menu Best, Most Economical for Efficient Food Service

A nonselective menu for the small hospital can be as efficient and satisfying and, if used correctly, more economical than a selective menu, according to Catherine Reinheimer, administrative dietitian, and LaVonne Wyffels, therapeutic dietitian, Midway Hospital, St. Paul. The hospital has 130 beds.

Each new patient, within a day of his admission to Midway, is visited by one of the dietitians and his food preferences in general are recorded on a file card. This initial conference and its implied assurance that the hospital is interested in him as an individual goes far toward gaining the patient's acceptance of the menu offerings at the hospital, the dietitians believe.

A typical list of food preferences might read: skim milk with all three meals; one slice of toast (the hospital would ordinarily serve two slices for breakfast), one-half square of butter instead of the usual one that is served, no fish except tuna, and no asparagus or broccoli.

"We try to cut waste right where it is likely to happen—before it happens," Miss Reinheimer explains.

The unified menu prevents the patient from a selection that might result in an unbalanced meal. Also, food costs are better controlled because patients faced with a choice of items are more likely to choose the more expensive one, the two women point out.

Miss Wyffels has found, by deliberately waiting to check a patient until his second day of hospitalization, that merely expressing his preferences to someone in authority means that he is more likely to accept future items on his tray. The patient feels, and rightly so, that he is being catered to and his initial attitude toward the food he is served is positive, rather than negative.

The patient is not encouraged to list special food likes—the menu is not tailored to that extent—but only the foods he will not eat or wants smaller portions of, and so on. Since each patient is interviewed only once, the Midway dietitians believe there is a saving of labor over the selective menu system, which involves making the rounds daily with a menu list, mimeographing and other clerical work, and counting of various servings required.

HOLD DOWN RAW FOOD COSTS

The savings made possible through Midway Hospital's nonselective system hold raw food costs to 37 cents per meal per person, including the operation of the employes' cafeteria, the dietitians report. This is possible despite the inclusion of frequent appetite tempters such as roast beef, avocados, fresh strawberries, and grapes.

Coupled with the nonselective menu is central serving. All trays are assembled in the kitchen and then transported by dumb-waiter to the proper floors. This system permits the dietitian a final check on each tray. Using the current listing of file cards, the dietitian double-checks special diets and the notes on patients' food preferences.

This dietetic check serves as a final measure against a patient's demanding replacements for food items during the rush of mealtime serving. Everything possible has been done to make sure the patient gets what he should have, medically speaking, and what he wants, also.

More efficient use of leftovers also is possible this way, since the dietary department staff can, with the single menu, judge more accurately what the consumption of food will be, the dietitians conclude. #

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Menus for July 1958

1 Pink Grapefruit Half Link Sausage • Grenadine Fruit Punch Roast Lamb With Mint Jelly Parsley Potatoes Cauliflower au Gratin Pear, Cheese Salad Chocolate Pie • Chicken Okra Gumbo Minced Ham on Toast Baked Mashed Potato Carrot, Raisin Salad Frosted Cupcake	**2** Stewed Apricots Poached Egg • Vegetable Soup Baked Virginia Ham Mashed Potatoes Baby Lima Beans Lettuce Hearts Banana Pudding • Beef Broth Cold Plate: Sliced Roast Beef, Potato Salad, Sliced Tomatoes and Pickles Pear, Cottage Cheese Fresh Berry Cup	**3** Baked Apple Bacon • Cream of Tomato Soup Salisbury Steak, Gravy Oven Browned Potatoes Cut Green Beans Pineapple, Grated Cheese Salad Vanilla Ice Cream • Beef Soup Cold Plate: Chicken Salad, Deviled Eggs, Spiced Crabapple and Coleslaw Potato Chips Chocolate Brownies	**4** Frosted Strawberries Scrambled Eggs • Cream of Vegetable Soup Broiled Fish Parsley Potatoes Baked Eggplant Lettuce Hearts With Russian Dressing Watermelon • Cream of Tomato Soup Tomato Stuffed With Tuna Fish Salad Baked Potato Fruit Salad Chocolate Pudding	**5** Grapefruit Juice Poached Egg, Bacon • Chicken Noodle Soup Yankee Pot Roast With Vegetables Fresh Fruit Salad Old Fashioned Bread Pudding • Cream of Spinach Soup Shepherd's Pie Baked Potato Mixed Vegetable Salad Chocolate Ice Cream	**6** Fresh Bananas Canadian Bacon • Jellied Consommé Baked Chicken With Dressing, Gravy French Green Beans Assorted Olives Raspberry Sundae • Chicken Broth Veal Stew With Dumplings Fresh Fruit Cup
7 Applesauce Hard Cooked Egg, Bacon • Chicken Broth Broiled Calves Liver Buttered Rice Buttered Turnip Greens Tomato Salad Coconut Cake • Cream of Spinach Soup Creamed Turkey on Toast Baked Potato Molded Pear in Lemon Gelatin Salad Peanut Butter Cookies	**8** Cantaloupe Fried Egg, Bacon • Pineapple Juice Fantail Shrimp With Ketchup Cups Parsley Potatoes Steamed Okra, Vinegar Coleslaw Watermelon • Green Split Pea Soup Welsh Rabbit on Toast Baked Apples With Cherries and Honey	**9** Apple Juice Poached Egg, Bacon • Vegetable Soup Roast Veal Leg Mashed Potatoes Green Peas Banana Nut Salad Gingerbread With Whipped Cream • Chicken Consommé Cold Sliced Chicken Baked Potato Lettuce Hearts With 1000 Island Dressing Apple Tarts	**10** Stewed Fresh Pears Bacon, Grape Jam • Cream of Mushroom Soup Roast Beef With Gravy Buttered Rice Mashed Yellow Squash Mixed Vegetable Salad Deep Dish Peach Pie • Vegetable Soup Broiled Beef Pattie Macaroni and Cheese Sliced Tomato Salad Fruit Cup	**11** Stewed Cinnamon Apple Breakfast Rolls • Fresh Vegetable Soup Deep Sea Scallops With Tartare Sauce Baked Potato Spinach Tomato, Lettuce Salad Lemon Cake • Fresh Shrimp Cocktail Scrambled Eggs Baked Potato Fresh Fruit Salad Sugar Cookies	**12** Fresh Tangerine Sausage Links • Chicken Noodle Soup Broiled Beef Steak Sliced Harvard Beets Mashed Potatoes Mixed Vegetable Salad Chocolate Ice Cream • Cream of Spinach Soup Chicken Salad on Lettuce Leaves With Tomato Quarters and Deviled Eggs Pear, Cottage Cheese Cupcake Topped With Ice Cream, Sirup
13 Grapes Canadian Bacon • Fruit Cup Baked Turkey, Dressing Mashed Potatoes Sliced Carrots Celery Hearts, Olives Walnut Ice Cream • Vegetable Soup Creamed Eggs on Toast Asparagus Salad Marble Cake	**14** Fresh Banana Fried Egg, Bacon • Chicken Broth Broiled Liver Escalloped Potatoes Green Peas Lettuce Hearts With Roquefort Cheese Dressing Apple Upside Down Cake • Cream of Tomato Soup Tuna Fish Pie Baked Potato Fruit Salad Sugar Cookies	**15** Stewed Apricots Sausage Links • Cream of Vegetable Soup Roast Beef au Jus Buttered Flaked Rice French Green Beans Chef's Salad With French Dressing Chocolate Pudding • Chicken Broth Chinese Chow Mein With Crisp Noodles, Soy Sauce Grapefruit Salad Fruit Cup	**16** Pineapple Juice Hard Cooked Egg • Chicken Noodle Soup Veal Stew Mashed Potatoes Buttered Spinach Tomato Salad Boston Cream Cake • Chicken Broth Beef Pattie Baked Potato Waldorf Salad Fruit Cup	**17** Grapes Link Sausage • Beef Broth Roast Lamb Parsley Potatoes Green Lima Beans Tomato Salad Apple Pie • Cream of Potato Soup Macaroni and Cheese Mixed Vegetable Salad Peanut Butter Cookies	**18** Orange Half Breakfast Rolls • Fresh Vegetable Soup Fried Fillet of Fish With Tartare Sauce Mashed Potatoes Buttered Whole Beets Lettuce Hearts Fresh Peach Shortcake With Whipped Cream • Shrimp, Okra Gumbo on Rice Mounds Julienne Carrots Coleslaw Fresh Fruit Cup
19 Strawberries Poached Egg • Chicken Broth Broiled Pork Chops Parsley Potatoes Chopped Spinach, Egg Banana Nut Salad Chocolate Ice Cream • Pineapple Juice Escalloped Ham and Potatoes in Casserole Buttered Vegetables Sliced Tomato Fresh Fruit Cup	**20** Baked Apple Fried Egg, Date Muffin • Jellied Tomato Consommé Broiled Chicken Sweet Potato Escalloped With Apples Sliced Carrots Strawberry Sundae • Beef Broth Cold Plate: Sliced Roast Beef, Potato Salad and Deviled Egg Melon Ball Compote	**21** Orange Half Hard Cooked Egg • Split Pea Soup Broiled Calves Liver Mashed Potatoes Mashed Rutabagas Peach, Cheese Salad Applesauce Cake With Hard Sauce • Vegetable Soup Italian Spaghetti With Meat Balls Beet, Green Bean Salad With French Dressing Fresh Fruit Cup	**22** Stewed Apricots Scrambled Eggs • Tomato, Okra Soup Broiled Beef Pattie in Gravy Escalloped Cauliflower With Peas and Eggs Lettuce Hearts With 1000 Island Dressing Banana Cream Layer Cake • Cream of Potato Soup Grilled Canadian Bacon With Pineapple Tossed Vegetable Salad Strawberry Tarts	**23** Stewed Apples Bacon, Jelly • Vegetable Soup Baked Ham Potatoes O'Brien Escalloped Tomatoes With Cabbage and Bacon Asparagus, Egg Salad Lemon Chiffon Pie With Whipped Cream • Cream of Tomato Soup Cold Plate: Sliced Roast Beef, Tomato Salad, Potato Chips Pumpkin Custards	**24** Grapefruit Half Sausage Links • Fresh Vegetable Soup Broiled Pork Tenderloin Buttered Rice Buttered Peas Coleslaw Chocolate Ice Cream • Beef Broth Sliced Chicken Baked Potato Waldorf Salad Sugar Cookies
25 Applesauce Scrambled Eggs • Fresh Vegetable Soup Fried Fillet of Fish Mashed Potatoes Buttered Beets Lettuce Hearts With Russian Dressing Peach Shortcake With Whipped Cream • French Onion Soup Shrimp Creole on Rice Julienne Carrots Coleslaw Fresh Fruit	**26** Stewed Prunes Sausage Links • Cream of Tomato Soup Turkey à la King on Toast Mashed Potatoes Green String Beans Sliced Tomato Salad Strawberry Ice Cream • Fresh Vegetable Soup Baked Vermicelli and American Cheese Casserole Tossed Chef's Salad With French Dressing Coconut Pudding	**27** Fresh Frosted Peach Canadian Bacon • Chilled Apple Juice Baked Virginia Ham Mashed Sweet Potatoes Buttered Lima Beans Assorted Olives Chocolate Sundae • Beef Broth Creamed Chipped Beef With Egg Slice Fruit Cup	**28** Frosted Strawberries Fried Egg, Bacon • Breaded Veal Cutlets With Cream Gravy Parsley Potatoes Green Asparagus Peach, Cottage Cheese Chocolate Layer Cake • Green Split Pea Soup Cold Sliced Chicken Baked Potato Mixed Vegetable Salad Fruit Cup	**29** Baked Apples Sausage Links • Chicken, Okra Gumbo Stuffed Baked Pork Chop Buttered Rice Pineapple, Cream Cheese Salad Vanilla Ice Cream • Chilled Pineapple Juice Cold Plate: Chicken Salad, Tomato Quarters and Deviled Egg Coconut Pudding	**30** Fresh Frosted Peach Scrambled Eggs • French Vegetable Soup Salmon Loaf With Cream Sauce Parsley Potatoes Green Peas Coleslaw Orange Sherbet • Chicken Broth Macaroni and Cheese Tossed Green Salad Jelly Roll

31 Orange Half, Scrambled Eggs • Cream of Mushroom Soup, Broiled Calves Liver, Mashed Potatoes, Buttered Broccoli, Pear, Cottage Cheese, Butterscotch Pie • Vegetable Soup, Toasted Cheese Sandwich, Tomato Salad, Fruit Cup.

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Radio Page Locates Doctors in 30 Seconds

Small receiver unit carried by each key staff member permits the hospital switchboard operator to locate him regardless of where he may stray within the building or on the grounds

Charles F. Stumpf

A RADIO page system affords key staff members constant contact with the paging source. Each person is equipped with a small radio receiver, which is tuned to the hospital's frequency. A transmitter located in the hospital emits messages on radio waves that are inaudible to patients, visitors and other employes. Only those equipped with receivers are aware that the system is in operation and, further, in selective radio paging only the person being paged hears the call.

Selective radio paging frees the individual of the necessity for scanning call light boxes or cocking one ear to a loudspeaker. He is freed of a great deal of the "on call" anxiety and can relax and devote his full attention to the work at hand.

The radio page system installed at the Beth Israel Hospital in Boston has proved to be both practical and extremely effective. Key personnel can be reached anywhere within the institution or its adjacent grounds. Paging operators have learned to expect responses within 30 seconds.

This radio page system utilizes a compact FM transmitter which requires a loop antenna. The antenna is looped around the buildings once for every three or four floors of height. The radio waves transmitted from this antenna effectively permeate all areas of the hospital, including lead lined x-ray rooms and parking areas adjacent to the buildings. No federal license is required, nor does the system interfere with diathermy, EEG or similar equipment.

The individual receivers, which are slightly larger than a package of king-size cigarets and weigh 10 ounces, contain tiny transistors, an antenna, a small mercury battery, and a speaker. Each receiver is identified by a number stamped on the case. This number corresponds to the frequency assigned to the receiver.

The paging operator uses an instrument that resembles a dial telephone. To initiate a page call, the operator picks up the hand piece and dials the number stamped on the receiver carried by the person being paged. A red light on her instrument blinks on, indicating that an alarm signal is being transmitted to the particular receiver. The receiver being paged responds immediately to this alarm signal by emitting an audible "beep."

If the voice feature is used, the paging operator waits four seconds for the red light to blink off and speaks into the telephone-like hand piece. The person being paged, upon hearing the alarm signal, depresses the "push to listen" plunger on his receiver and hears the voice message through his tiny speaker.

This voice feature is not currently being used at Beth Israel because the paging operator cannot be assured that the spoken message has been heard. The system is not two-way and the person being paged may have his set turned off or may have left the hospital without informing the paging operator. The recipient, upon hearing the alarm signal, goes to the nearest telephone, dials the paging operator, and receives the message.

By using only the selective alarm signal and requiring a call back to the paging operator, we provide a check on all messages. In addition, we are able to relieve the busy nursing staff of the responsibility of initiating repeated page calls. The paging operator assumes the responsibility for locating the individual and giving the message after the initial request.

SELECTING A SYSTEM

A variety of radio page systems is now available. Others are in the development stage. Most radio page systems are sold outright, but in some areas they may be installed on a lease basis. Whether they be leased or purchased, the basic considerations remain the same.

Ten important questions that should be answered before selecting a radio page system accompany this article. (See Page 124.)

In selecting a radio page system

Charles F. Stumpf developed the procedures and guided the installation of the selective radio page system at Beth Israel Hospital, Boston, where he is administrative assistant. The paging system was the first of its kind on the eastern seaboard. Mr. Stumpf was graduated from Seton Hall University and received his master's degree in hospital administration from Washington University. He served his administrative residency at Brooke Army Hospital, San Antonio, Tex., and was a medical service officer in Korea. Mr. Stumpf is a nominee of the American College of Hospital Administrators.

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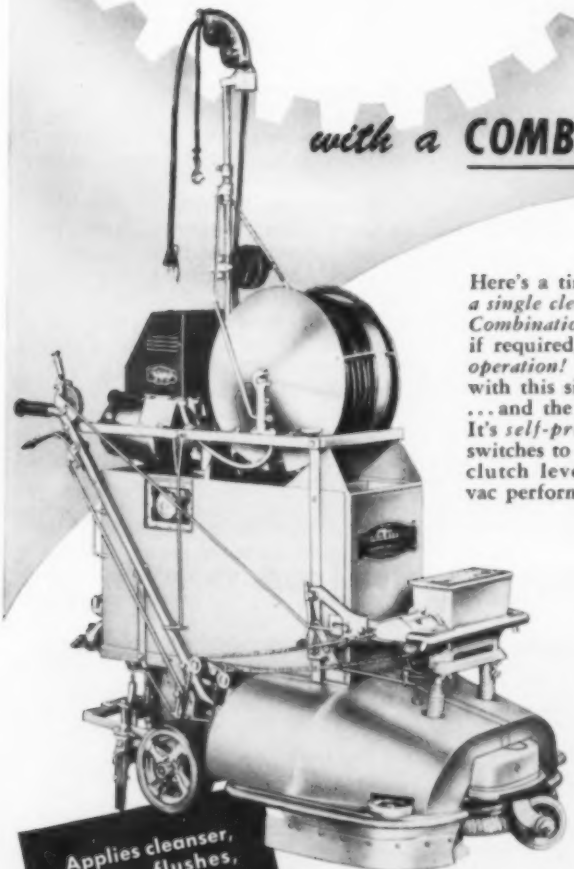

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HOW TO SELECT A PAGING SYSTEM

1. What are the installation problems? Does the system require extensive antenna wiring? Is an F.C.C. license required?

2. Does the system pick up interference? Will electrical machinery, near-by radio transmitters, or other radio paging systems interfere with the signal? Will near-by hospitals or other industries install a system? Is the signal clear? **Insist upon a demonstration.**

3. What is the size and weight of the receiver? Is it easily carried in hospital uniforms?

4. How is the call transmitted and received? Is the operation simple and dependable? Can the user determine whether or not he is within reach of the paging source?

5. Can the system be expanded? How many receivers will the system carry? What additional transmitter equipment will be needed? Are remote paging stations available?

6. What maintenance will be required? Are local repair facilities available for both the transmitter and the receiver? How long will a battery last? Are rechargeable batteries available?

7. Does the system provide a voice feature? Is the voice message received through an ear plug, a lapel speaker, or through a receiver mounted speaker? Is the voice message clear and static free?

8. Is the system selective? Do all users listen in on a "party line" or do they hear only those messages destined for them?

9. What is the cost? How does it compare with the cost of installing a conventional paging system? What is the upkeep cost, and how much are the batteries? What savings can be effected through improved personnel utilization? Will it improve patient care in your institution?

10. Who is the manufacturer? Who is the dealer? Are they reliable? Has their product been fully developed or is it still "experimental"?

developments yet to come should also be considered. There is a definite need for two-way communication. This refinement would at least enable the user to signal receipt of the message if not to reply or converse directly with the caller.

A logical step following the development of two-way communication might be a tie-in with existing dial telephone equipment which would enable the hospital staff to "dial" the user directly without benefit of a paging operator.

Citywide paging from the hospital switchboard would be helpful to many institutions and particularly to those with little or no house staff coverage.

INSTALLING A SYSTEM

The hospital maintenance department should supervise installation of the transmitter and the antenna loop if one is required, noting its route on the set of master floor plans or blueprints. The transmitter is best located with or near existing telephone equipment for accessibility. Remote paging centers may be located at key points, such as at the information desk.

When the installation is complete and all areas of the hospital have been carefully tested for proper reception, receivers may be distributed. This must be carefully planned to keep transfer of assignments to a minimum. Frequent switching of receivers will cause confusion for the paging operator.

In most hospitals, distribution to busy house officers will be considered first. Others who will utilize the system to great advantage will be night watchmen, various technicians and orderlies, the hospital engineer, administration and nursing supervisors. Somewhat unusual advantages may be obtained by assigning a receiver to such employes as the roving bulb changer or to messengers who might then be centrally dispatched.

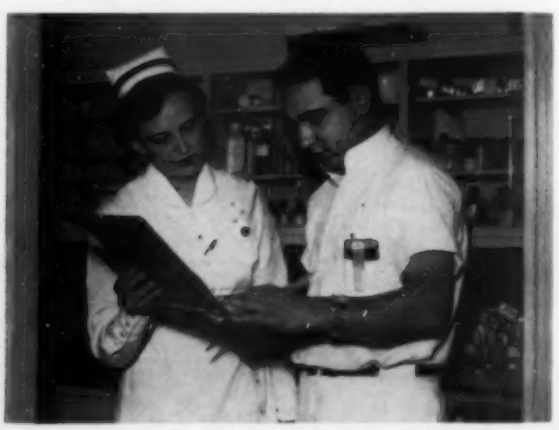
Distribution to the visiting medical staff requires a different approach both in quantity and manner of acquisition and in actual utilization. The hospital may provide receivers for the physicians or they may rent, lease or sell them to the staff. They may be assigned individually or issued from a central "pool." Since these physicians are usually not "full-time" personnel, the manner of utilization will vary.

Prior to actual distribution, all procedures relating to the system should be worked out on paper and a system of control over assignment of receivers inaugurated.

Detailed instructions in the care and use of the instruments should be reproduced for issue with each receiver. These instructions should answer any questions the user may have pertaining to the system and, if they are adequate, they will discourage tampering.

A system of control over the assignment of receivers is necessary to reduce confusion to the paging operator and to prevent the loss of valuable equipment. (*Cont. on p.* 126)

Annette Makino, chief switchboard operator at Beth Israel Hospital in Boston, is shown initiating a radio page call. She can expect a response to the call within 30 seconds.



Dr. Jose Guzman, talking with Helen Sawitsky, is carrying a radio page receiver. With it, he can be reached instantly anywhere within the hospital or its grounds.

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A central control point should be established at the telephone switchboard, the information desk, or the maintenance department. We chose the maintenance department since the personnel of this department is best suited to evaluate the instruments and make minor repairs.

The assignment of a radio page receiver is best initiated by administration in a written request to the central control point asking that a receiver be issued. We use the lower half of this assignment request as a receipt form and require that the individual sign for his receiver.

The individual user assumes responsibility for the receiver but it is desirable to provide a place where he may check his receiver for safekeeping while he is off duty. We have provided a rack at the information desk for this purpose. Though the receivers are small, we have experienced no losses.

One incident was reported which might explain our good fortune in this respect. The paging operator received a request to "beep" Dr. Smith. She recognized the voice of the caller and exclaimed, "But this is Dr. Smith, is it not?" Dr. Smith replied in the affirmative and explained that he had misplaced his receiver and thought that if she "beeped" him, he could locate it. The paging operator complied with the request and Dr. Smith and his "beeper" were soon reunited.

Prior to issue, the prospective user is instructed in the care of the instrument and the operation is demonstrated. These instructions are simple and brief but necessary. The signed receipt form is then placed in the permanent record jacket set aside for the particular instrument. The paging operator is notified, the unit is tested, and the user is "on the air."

Adequate planning, effective control, and explicit instructions will reduce the problems of actual operation to a minimum. There are, however, a few areas which must be explored before the radio page system is put "on the air."

As noted previously, the mainteance department services all the receivers and replaces batteries as needed. This service is provided around the clock to accommodate those on night call. A permanent record jacket for each instrument is also maintained. A list of users and repairs is recorded on this jacket and the current receipt form is filed within.

The radio page receivers, though they operate on a low voltage, are not explosionproof and should not be carried into an operating room. We have provided a rack at the OR entrance and within reach of the secretary's desk in which the receivers are placed. We ask that they be left turned "On" so that the operating room secretary may receive calls for those who are "in scrub."

We plan to expand our 50 receiver system to include the visiting medical staff. It is anticipated that members of the staff will "subscribe" to the service and draw receivers from a central "pool" at the information desk as they check in. We foresee a problem wherein they might, on occasions, leave the hospital in a hurry without returning their receivers. To control this possible breakdown, we plan to ask staff members to deposit their car keys in exchange for the receiver. The keys would be placed in the rack that is provided for the instrument and returned when the receiver was turned in.

A foolproof system of checking people in or out with the paging operator is necessary to ensure effective paging. This problem is not peculiar to radio paging as any system will break down without good communication between the paging source and the person being paged. A radio page system, since it is so effective, will, however, amplify the problem. #

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Laundries Make or Mar Sheet Life

For the longest possible wear from textiles, wise choice of a reliable laundry is most important

Ruth Emma Weisheit and Rose W. Padgett

BUYING textiles is becoming more and more complicated. Consumer and purchasing agent are finding that the label is not giving sufficient information to ensure a wise buy. Consequently, purchasing agents are turning to textile testing to find the answers.

The recent publication of the American Hotel Association's L24 minimum standards has provided the purchasing agent with a necessary guide to buying. However, when facilities are available, actual scientific tests may be performed in the textile laboratory to determine the best buy within the selected group of desired goods.

At Purdue University, two major problems prompted this research: (1) Which is a better buy, muslin or percale sheets? (2) Do commercial laundries mar sheet life?

The following three factors were considered when determining the proper buy: initial cost, laundry cost, and fabric performance.

Initial cost. We found that type 140 muslin had the lowest initial cost, type 180 percale was slightly higher, and type 200 percale was still more expensive. The initial cost is not the whole story.

Laundry cost. The 140 muslin is a heavier fabric than are the percales. A muslin sheet weighed 24 ounces while the percales averaged 20 ounces per sheet. Over a period of time, this additional weight of the muslin sheeting would cause the laundry cost of the muslin to exceed that of the percales, thus making the muslin a more expensive sheeting. Taking into consideration the initial cost and the laundry cost, we found that type 180 percale was the least expensive.

This work was done as a partial fulfillment of the requirements for an M.S. degree at Purdue University by Miss Weisheit under the direction of Dr. Padgett.

Fabric performance. Regardless of the cost of the fabric, if the material will not withstand use and laundering, the expense is increased. Fabric performance is an important fact to be considered when buying textiles. In this study, in order to determine the fabric performance, the sheets were commercially laundered 100 times. It was found that type 180 rated best in dimensional change of the original fabric, breaking strength after laundering, and weight of fabric.

Dimensional change of original fabric. Five samples of each sheeting, randomly chosen, were used to determine the dimensional change of the original fabrics according to the American Association of Textile Chemists and Colorists' rapid control test for shrinkage equivalent to five commercial launderings. The samples were washed twice by this method (Method 72-52), which was the equivalent of 10 commercial launderings. Our study showed that type 180 percale had the least amount of over-all shrinkage.

SHEET STRENGTH

Breaking strengths were taken on the original sheeting by both the "grab" and the "ravel strip" methods as recommended by the American Association of Textile Chemists and Colorists. We used the former breaking strength method to determine whether the original sheeting met the recommended American Home Economics Standards for sheets. We found that all the sheets tested met the standards, namely:

Type of Sheet	*Warp and Filling Breaking Strength of Lbs. per Inch*
Muslin 140	70
Percale 180	60
Percale 200	60

We employed the ravel strip method of breaking strengths to determine the sheet strength after laundering and found that type 180 percale had the highest breaking strengths after 100 commercial launderings.

Weight of fabric. The weight of the fabric was determined as outlined by the American Society for Testing Materials. In our study we found that type 180 and one of the 200 percale sheetings were the lightest fabrics, weighing 19.8 ounces per sheet. The other 200 percale sheet weighed 20.5 ounces, and the 140 muslin weighed 24 ounces per sheet. This additional weight is a costly factor when the sheets are washed by a commercial laundry.

When buying sheets, purchasing agents and the consumer should take into account both fabric performance and total cost. Our study shows type 180 percale as the recommended best buy in bleached cotton sheeting.

FABRIC EASILY DAMAGED

The life of a sheet is greatly dependent upon the laundry process. Regardless of the properties of the original sheeting, if proper care is not taken during the cleaning process, damage to the fabric can occur. This damage will reduce the life of a sheet.

The purchasing agent and the research worker wished to know if there was a difference in the effects of various commercial laundries on sheets. One set of sheets consisting of four sheets of each of type 140 muslin, type 180 percale, and two brands of 200 percales were sent to each of the three selected commercial laundries. The sheets were washed a hundred times.

The three types of damage that may occur during the laundering process are: (1) *mechanical* damage caused by excessive agitation during the wash-

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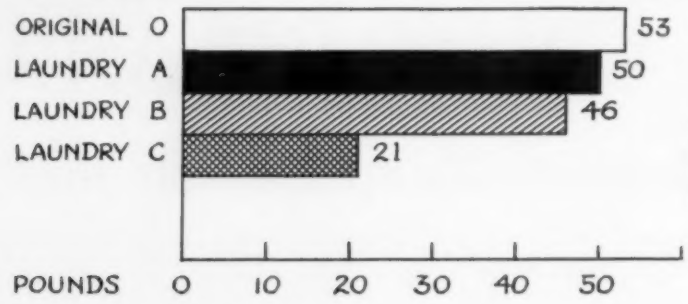

Fig. 1—Comparison of average breaking strength of test sheet before and after washing by commercial laundries.

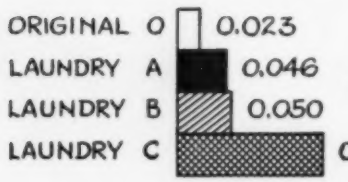

Fig. 2—Average copper numbers of test sheet before and after laundering by the three commercial laundries.

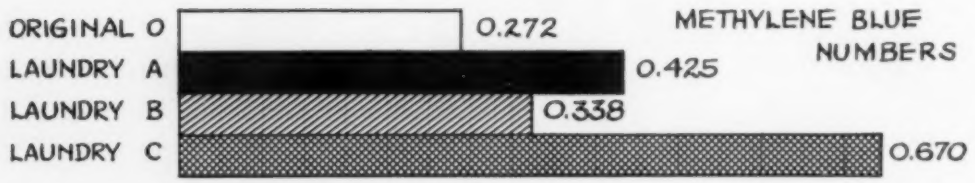

Fig. 3—Average methylene blue numbers of test sheet before and after laundering by three commercial laundries. Highest number shows greatest damage to cotton sheeting.

ing cycle, (2) *heat* damage caused by too hot water, prolonged drying at too high temperatures, and excessive ironing temperatures, and (3) *chemical* damage caused by overbleaching. Damage to the fabric causes a decrease in the strength.

General fabric damage includes all three types of wash damage. In this study general fabric damage was determined by a comparison of the breaking strengths of the sheetings tested, before and after laundering. A statistical analysis showed that the four types of sheets reacted the same when washed by one laundry. However, there was a significant statistical difference in the effects of the various types of commercial laundries.

Figure 1 shows a comparison of the average breaking strengths of an original test sheet and breaking strengths of sheets laundered 100 times by the three selected commercial laundries. This bar graph is typical of the results obtained during testing. The original ravel strip* breaking strength was 53 pounds. Laundry A sheet samples had a breaking strength of 50 pounds, laundry B sheet samples had a breaking strength of 46 pounds, and laundry C sheet samples had a breaking strength of 21 pounds.

This reduced strength means a reduced wear life for the sheet and an increase in cost to the purchasing agent or consumer.

Chemical damage was determined by the copper number and the methylene blue number of the laundered sheetings. Once again, we found that there was a great difference in the damage to the fabric, as shown in Figure 2. The copper number of the original fabric was 0.023. After a hundred commercial launderings by one laundry, the copper number was 0.046; by another laundry it was 0.050, and by the third laundry it was 0.140. The higher the copper number, the greater the damage.

The methylene blue number followed the same pattern, as shown in Figure 3. The methylene blue number of the original fabric was found to be 0.272. After a hundred commercial launderings, the samples sent to one of the three commercial laundries had an average methylene blue number of 0.425. The second had an average of 0.338, and the third an average of 0.670.

The highest methylene blue number shows the greatest damage to the cotton sheeting.

The test results shown in Figure 3 indicate that there is a great difference in the effects of various commercial laundries upon sheet wear or sheet damage caused by laundering. To obtain the longest possible wear from textile fabrics a wise choice of a reliable laundry is most important.

COMMERCIAL LAUNDRY PROCEDURE

Today's commercial laundries follow the white work basic wash formula recommended by the American Institute of Laundering or the American Hotel Association. Sheeting falls into the white work class. The American Institute of Launderings recommended formula is as follows:

To prevent bleach damage, use 1 quart of 1 per cent chlorite bleach per hundred pounds of material and never more than 2 quarts of 1 per cent bleach per hundred pounds wash load. Control the bleach bath temperature carefully; the temperature

*The ravel strip breaking strength is always lower than that of the grab method. Since standard recommended breaking strengths were given for the grab method, the 70 pounds for muslin and 60 pounds for percales only applies to breaks made by the latter method. The ravel strip method requires less fabric per break and, in order to make the numerous breaks required for this sheet testing, the ravel strip method was used on both original and laundered samples. The grab method was used on original sheets only.

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BASIC WASH FORMULA FOR WHITE WORK

Operation	Water Level (Inches)	Time (Minutes)	Temperature (Degrees F.)	Supplies
Suds	7	5-10	100	soap and builders to running suds
Suds	5	5-10	125	as above
Suds	5	5-10	140	as above
Suds	5	10	150	as above plus bleach
First rinse	12	3	hot	none
2d rinse		3	hot	none
3d rinse		3	hot	none
4th rinse		3	130	none
5th rinse		3	120	none
Sour and blue	At correct pH at a suds water level at about 120 F. for five minutes, and drain the bath.			

should never exceed 150°F. Fabric weakness may result from high temperatures, which cause bleach to act violently on linens. If live steam is used to heat the water, close the steam valve before adding the bleach. Careless addition of bleach directly onto the wash load tends to weaken the fabric at the points of contact.

Bleach should not contain sediment from the bottom of the crock or scum from the surface of the liquid since undissolved particles of bleach may tenter or hole the fabric. Rust stains should be removed from linens before washing since rust has an affinity for bleach and may cause fabric damage and holes.

The use of a clock in the wash room to time the operations is important. Experts agree that, in good laundries, bleach is the only supply which, if used improperly, can damage or shorten linen life.

For pH control, the pH scale enables laundrymen to measure the acidity and the alkalinity of wash loads, to standardize wash room procedures, and to eliminate expensive guesswork. Small laundries without ready access to a laboratory can do an on-the-job determination using pH test papers that register accurately to within 0.3 pH.

The following standards should aid wash men to put out higher quality work: A pH from 11.0 to 11.6 is excellent for the first suds, or break, on medium or heavy soil. A pH of 10.6 on the break is recommended for light soil and for all other suds regardless of the degree of soiling. A pH of 10.4 to 10.6 has proved best for bleaching. A pH of 10.0 plus is recommended for all first rinses. The sour pH for acetic acid is between 5.4 to 6.0, and a pH of 5.0 should be used for all other sours.

Tests showed that sheets sent to laundries A and B had only a small amount of fabric wear after a hundred commercial launderings. One of these two laundries works closely with a research station and attempts test controlled technics; therefore, it was selected as a standard for the study. Most experts agree that, in the long run, linen life is largely dependent on the washing process. Consequently, it appears that the reliability of a laundry may be mainly dependent upon the knowledge and efficiency of wash room technicians.

The marked damage to sheets laundered by laundry C appears to have been due to one or more of the following wash factors:

1. Prolonged washing operation. The mechanical action of the washer is responsible for tensile strength loss in linens.
2. Excessive or incorrect bleaching.
3. Too high a temperature for the bleaching water.

It is unlikely that the standard commercial flatwork ironer would create excessive ironing temperatures.

We recommend that, if you think a laundry is using excessive bleach, you can check the washing methods by using the American Hotel Association's test piece service for member hotels. It also is possible to obtain from commercial laundries a report in advance as to the percentage of concentration of their bleach and the approximate water temperature and ironing temperature levels.

In summary, we found in this study: (1) When initial cost, laundry cost, and sheet performance are taken into consideration, type 180 percale sheets are the recommended buy. (2) Laundries mar sheet life to a greater or less degree according to the individual laundry procedure, since in our study there was a marked difference in the strength loss of sheets within laundry treatments. A reliable laundry should be selected in order to maintain maximum sheet life.

Because purchasing agents are being faced with many hard decisions because of the increasing number of fibers and finishes on the market, textile testing is taking a major rôle in guiding both the purchasing agent and the general consumer in the care of goods and in the selection of the best buy. #

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- **Exclusive mechanical features drastically cut costs of installation, operation and maintenance!**

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Millions Live Better with York

State Seeks to Regulate Costs Through Blue Cross

(*Continued From Page* 51)

utilization and inform hospitals of the results.

8. Blue Cross plans must expressly request assistance of county medical societies in resolving abuses in hospital utilization, and the plans must explore Blue Cross contracts in other states to seek contract features that might tend to reduce unnecessary hospital utilization.

9. Blue Cross plans must establish a coordinating committee to study methods of reducing unnecessary hospital utilization and disseminate its findings to member hospitals. This committee can assist its member plans in providing continual vigilance of hospital administration, it was suggested.

In addition, the adjudication recommended establishment of a public commission to study "the whole system of hospital operations in Pennsylvania with the view of proposing administrative changes in hospital management, and for the purpose of determining proper legislative action."

The recommended commission would be representative of the state departments of health, insurance, public welfare, labor and industry, and would include other members representing Blue Cross, Blue Shield, hospitals and the medical profession. Listed as subjects for study by the proposed commission were:

1. Elimination of duplicated hospital facilities.
2. Reorganization of hospital facilities on a more efficient basis.
3. Facilities for the care of long stay or convalescent patients.
4. Expansion of outpatient care for patients not requiring hospital accommodations.
5. Improvements in internal operations of hospitals.
6. Organization of hospital facilities and services for better care of aged patients.
7. Review of government subsidies to hospitals for free care.
8. Methods for eliminating unnecessary utilization of facilities.
9. Charges for hospital service.

Finding that Blue Cross boards of trustees include too many representatives of hospitals and too few representatives of subscribing groups and the public, the commissioner also recommended that the plans review their by-laws for the purpose of increasing subscriber representation and directed that "in all future negotiations between Blue Cross and hospitals, negotiators for Blue Cross, in the majority, be persons who have no official connections with hospital administration, and thus be free to represent solely the interest of Blue Cross subscribers."

The commissioner condemned the practice of Blue Cross plans of meeting competition from commercial insurance companies by offering preferential or experience rating to certain groups. "To the extent that Blue Cross gives preferred rates to select groups without any additional payments by them to help bear a portion of the expense of the older subscribers, it is not fulfilling its community purpose," said the adjudication.

The commissioner referred repeatedly to testimony that was critical of physicians and hospitals for their failure to establish effective controls of unnecessary utilization. For example, he said, "Dr. Isadore Ravdin, chief surgeon at the Hospital of the University of Pennsylvania, testified in the Philadelphia hearings that he had been approached many times by patients who desired unnecessary hospitalization. He testified further that in his opinion abuses do exist. He stated in his testimony that if the staffs of hospitals were really backed by the strength of the county medical society and the board of censors they could do much to reduce the abuse of unnecessary hospitalization."

At another point, the adjudication referred to testimony by Dr. Samuel B. Haddon, former president of the Philadelphia County Medical Society, that hospital management urges physicians to keep hospital beds filled.

Failure of other hospitals to adopt the methods used by the Sacred Heart Hospital at Allentown was criticized by the commissioner. "If one hospital can institute such a plan with such outstanding success, it stands to reason that many more hospitals can do likewise," he stated. "Throughout all of these hearings not another single case where such a comprehensive program was undertaken by hospital and staff came to the department's attention. Testimony submitted in these hearings establishes beyond any doubt that unnecessary utilization of hospital service can be substantially reduced by proper action and cooperation of all interested parties. Any suggestion that we can't do anything about it because we don't know to what extent the abuses exist should be summarily rejected."

Similarly, the adjudication referred several times to testimony by Dr. C. Rufus Rorem, executive director of the Hospital Council of Philadelphia, that hospitals can effect economies through joint action programs. "I cannot accept the idea that there is no room for economies in hospital administration," said Commissioner Smith. #

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			5 min.	10 min.		5 min.	10 min.
3246	R	52, 52A	0	0	(Complete kill at 1:300 through 1:900)	0	0
3269	R	52, 42B, 81	0	0		0	0
126	R	7, 47, 53, 54, 73, 75, 77, VA_4	0	0		0	0

0 indicates complete kill.

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8400 Registrants Attend 36 Sectional Conferences at 28th Tri-State Assembly

(*Continued From Page* 53)

sisted that the advantages of accreditation make it economical in the long run.

An analysis of the hospital nursing education program, including a study of the curriculum in relation to patient needs, is the first step toward achieving accredited status, Miss Schwier said. Such analysis will also reveal areas in which help is needed, and the hospital school must be willing to call for and accept help, in order to achieve accreditation, she added.

Following Miss Schwier's presentation, the discussion revealed division of opinion among administrators and nurses in the audience on the control of student assignments and, especially, whether or not night duty is desirable for students in order to teach the concept that nursing is a "24 hour profession."

It remained for a physician, speaking at another session, to put a finger on the cause for a great deal of today's patient dissatisfaction with nursing service. The cause, said Dr. Hunter A. Soper, attending physician at Indiana University Medical Center, lies in the complexity and impersonality of medical care in the hospital.

The fact that as many as 25 different persons may visit the patient's bedside in a single day of treatment is likely to bewilder him, Dr. Soper said. Kindness is still the best tool in patient care, he told a conference of nurses and administrators, urging them to listen to patients.

There would be no patient care problem at all, Dr. Soper concluded, if everybody who went into the patient's room asked before leaving, "Is there anything else I can do for you?"

Something that hospitals can and should do for physicians was stated explicitly at a joint conference of medical staff members and trustees by Dr. Rudolph J. E. Oden, attending surgeon at Augustana Hospital, Chicago.

"Put doctors on the board of trustees," he said.

Pointing out that he had been a hospital trustee himself for "several decades," Dr. Oden blasted the reasons doctors should not be on hospital boards as they were set forth years ago by the late Dr. Malcolm T. MacEachern. "With these 10 ironical strikes against him, the doctor's recognition as an active member of the board is doomed from the very beginning," Dr. Oden declared. "To imply that they cannot meet the standards required by lay members is an affront to the medical profession."

Answering the charge that the physician board member may use his position for personal advantage, Dr. Oden said, "Any individual whose chief purpose of service is personal gain should never be considered as a hospital board member, regardless of his vocation."

It is entirely reasonable to expect that doctors should be effective members of the hospital board of trustees, Dr. Oden said, "because medicine is the business of the hospital."

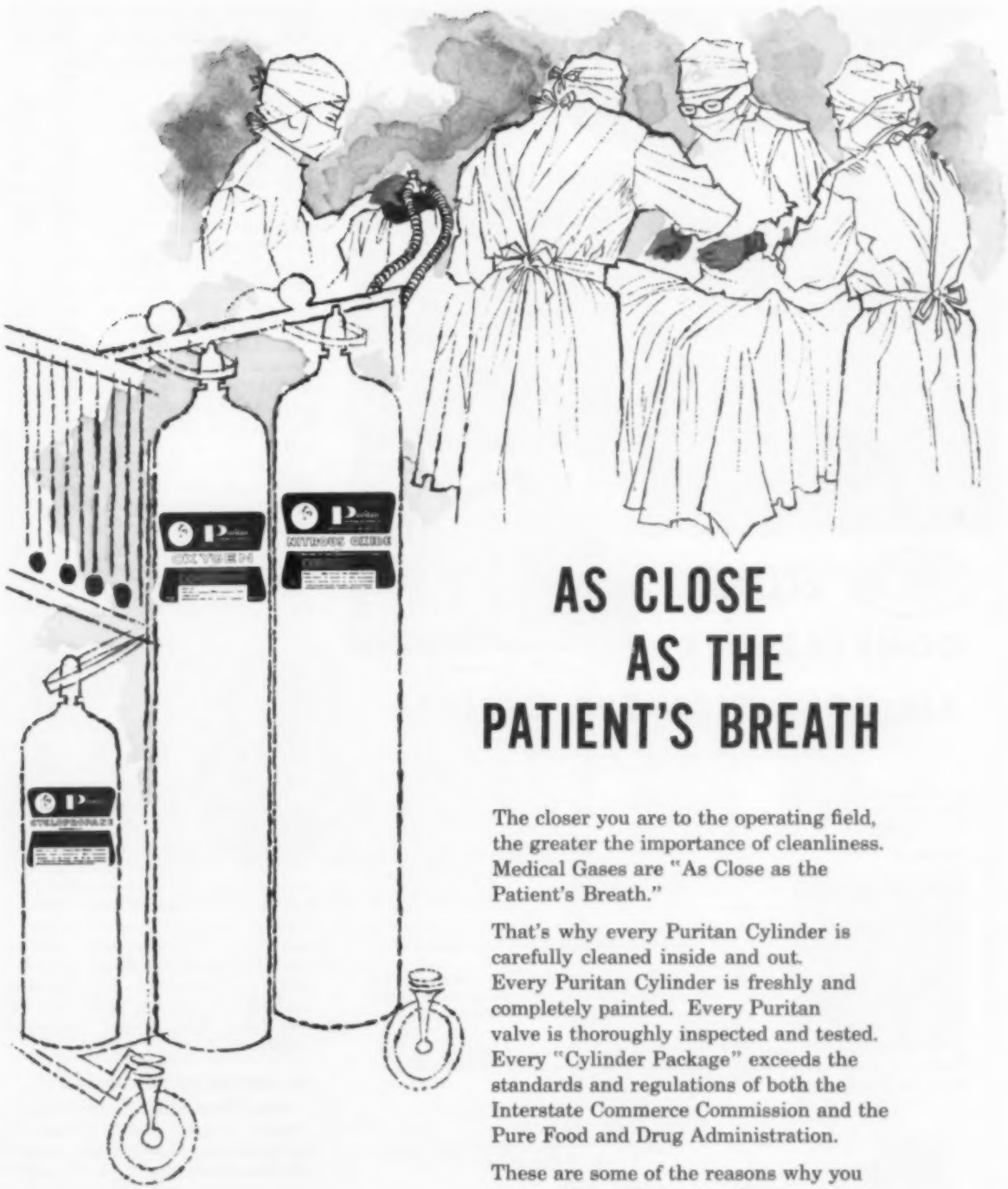
Receiving Tri-State awards of merit for the participating states were:

Illinois: Ralph Hueston, administrator of Chicago Wesley Memorial Hospital.

Indiana: Dr. Martha O'Malley, director of the Division of Hospital and Institutional Services, Indiana State Board of Health, Indianapolis.

Wisconsin: Reverend A. H. Schmeuszer, administrator of the Evangelical Deaconess Hospital, Milwaukee.

Michigan: Dr. Emory W. Morris, president and general director, W. K. Kellogg Foundation, Battle Creek. #



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Hospital to Take Service Into Its Community, West Coast Convention Told

(*Continued From Page* 54)

mittee on infections, Dr. Crosby said at a general session on national and state hospital association programs—a session at which charges that the Western states have been neglected in the A.H.A. appointments and programs were aired. Other A.H.A. services described were:

1. The new hospital consulting service that has been organized on a regional basis under a grant from the Ford Foundation.
2. Improved relations with professional groups such as the American Medical Association, radiologists, pathologists and others, made possible through joint liaison committees with A.H.A.
3. Advisory services, including institutes, manuals and monographs on such subjects as insurance, housekeeping, accounting, dietary service, and many other departments of hospital operation.
4. Research projects carried on through the research and educational trust of A.H.A.
5. A newly planned nursing department which will study all aspects of nursing service and education as part of the activity of the association's council on professional practice.
6. Legislative activities carried on by the A.H.A.'s Washington bureau.
7. Educational activities for trustees, auxiliary members, and volunteers.

Much as they may appreciate these and other association services, there are still some Western members who feel the West should have a greater voice in shaping association policy, it developed in a discussion that included some sharp exchanges between critics and supporters of the present methods of electing delegates and appointing council and committee members.

NO MATHEMATICAL FORMULA

When Howard B. Hatfield, administrator of Long Beach Community Hospital, Long Beach, Calif., pointed out that among more than 500 A.H.A. appointments, only 31 were from states in the Western Association, Dr. Albert W. Snoke of Connecticut, past president of A.H.A., replied that Nevada and Connecticut each had only one vote in the House of Delegates, although Connecticut has 10 times as many member hospitals as Nevada. "Let's not regiment our appointments on a mathematical formula," Dr. Snoke said.

Dispersed into sectional meetings, the convention applied itself to pro-

fessional rather than political problems. The new concept of zones or specialized care units was studied in detail by the Community Hospital Section, which heard discussions of intensive or acute care areas and convalescent care areas, and considered the impact of this zone concept on hospital costs.

The advantages of intensive care units were described by Lois Williams, supervisor of the intensive care area at Palo Alto Hospital, Palo Alto, Calif., and Kenneth E. Knapp, administrator of the Thomas Dee Memorial Hospital, Ogden, Utah. These units result in better care of patients and improved security and peace of mind for critically ill patients and their families, the speakers said. Success or failure of an intensive care unit depends largely on the doctors' willingness to use the service and their cooperation with nurses in supervising admissions and discharges, Miss Williams emphasized.

The convalescent unit at Huntington Memorial Hospital, Pasadena, Calif., has freed many beds in the hospital for patients needing acute service and resulted in economies for the convalescent patients, Gordon W. Gilbert, administrator, reported.

Everett W. Jones, hospital consultant, raised some questions about the intensive and convalescent care units. "What about the acutely ill patient who wants privacy and does not want to be in a room with other patients?" he asked. "Are we really setting up the intensive care unit as an open ward for the patient's well-being, or are we setting it up for our own convenience in giving intensive care with fewer nurses and hence less cost?"

Intensive care units will have higher than average costs but their establishment should reduce costs in the regular nursing units, Joseph L. Zem, director of St. Luke's Hospital, San Francisco, suggested. These units should also reduce the amount of special duty nursing which patients have to pay for, he pointed out.

Accurate cost determinations are needed to set up proper charges for care in intensive care units, regular units, and convalescent units, according to Mr. Jones. "Third-party payors will demand this cost information," Mr. Jones stated.

At a section meeting for administrative interns, residents and students, Dr. Snoke described the Iowa hospital-physician dispute and lawsuit as a "pain in the neck." The Iowa Hospital Association was badly advised when it sought to prove that radiology and pathology are not the practice of medicine, he said. "This was a serious error," Dr. Snoke declared. "Hospitals were clobbered by the circuit court."

Association Names Officers, Lamer Is President-Elect

San Francisco.—Wesley G. Lamer, administrator of Physicians and Surgeons Hospital, Portland, Ore., was named president-elect of the Association of Western Hospitals at the 28th annual convention of the group here last month.

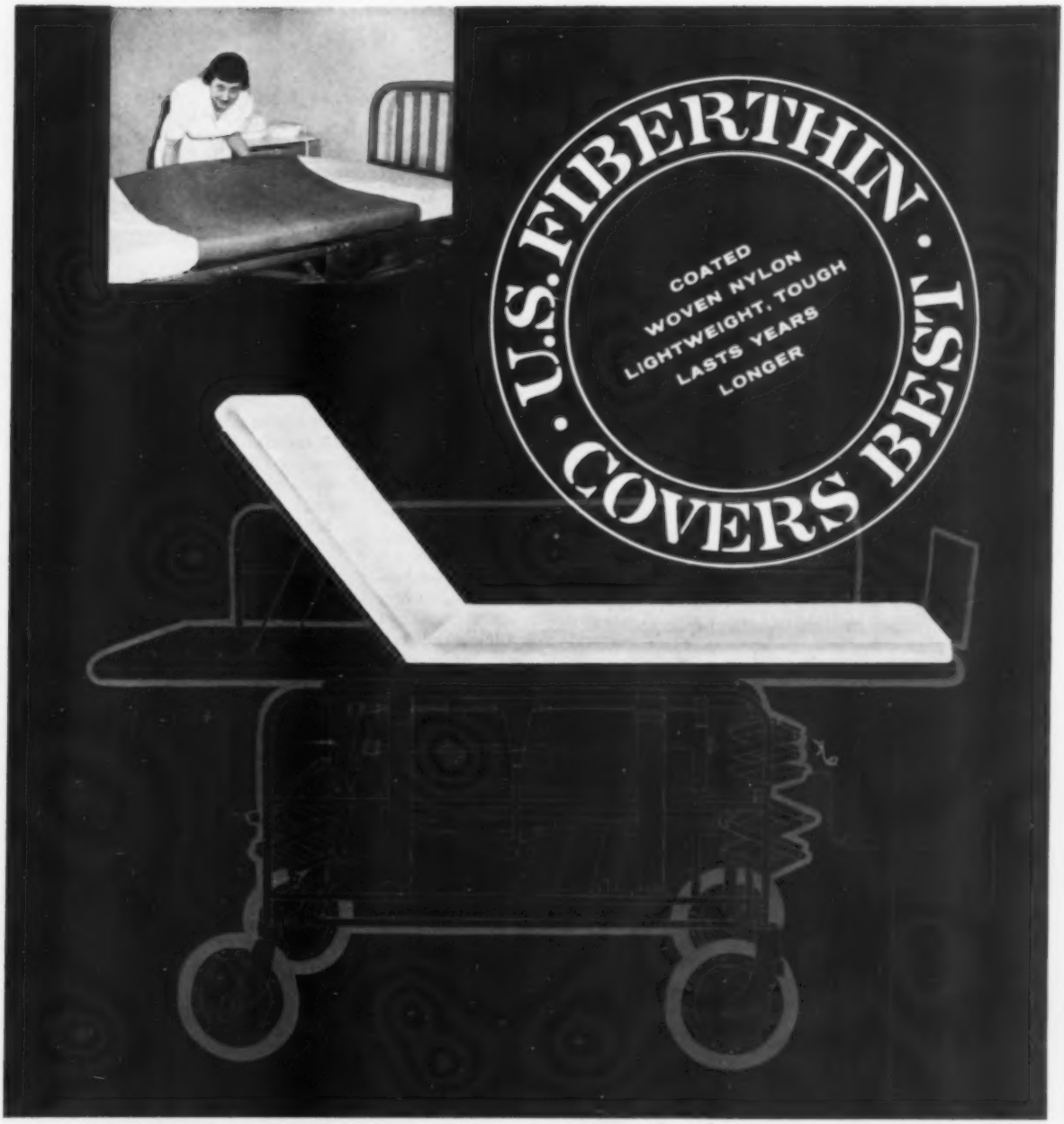
Mr. Lamer will succeed Ralph J. Hromadka, administrator of Santa Monica Hospital, Santa Monica, Calif., who became president during the convention.

Guy M. Hanner, Good Samaritan Hospital, Phoenix, Ariz., was the retiring president.

Other new officers elected by the association are:

First vice president, John H. Zenger, administrator, Utah Valley Hospital, Provo; second vice president, Sister Ann Raymond, administrator, St. Vincent Hospital, Billings, Mont.; third vice president, Paul S. Bliss, administrator, Vancouver Memorial Hospital, Vancouver, Wash.

Treasurer of the association is Joseph L. Zem, director of St. Luke's Hospital, San Francisco; executive secretary is Melvin C. Scheflin, San Francisco. #



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NEWS DIGEST

Progressive Care Can Lower Costs, Carolinas-Virginias Meeting Hears . . . Blue Cross Commission Names Garside Chairman . . . Government to Play Larger Rôle in Hospitals, Groner Says . . . New Jersey Court Overturns Immunity Doctrine

Progressive Care Is Answer to Rising Costs, McGuinness Tells Carolinas-Virginias Meeting

ROANOKE, VA.—Progressive or "graduated" patient care of the kind that has been tried out successfully at the Manchester Memorial Hospital in Manchester, Conn., was proposed as the solution to rising hospital costs in an address delivered here last month by Dr. Aims C. McGuinness, special assistant to the Secretary of Health, Education and Welfare.

Speaking at the 28th annual meeting of the Carolinas-Virginias Hospital Conference, Dr. McGuinness said the Department of Health, Education and Welfare was interested in a selective care plan "tailored to the immediate needs of the individual patient" and would issue two reports on the subject—a report on the Manchester Memorial Hospital, and a guide for hospitals on elements of graduated care, explaining how to meet some of the operating problems that are encountered by hospitals in this system.

More than 2000 hospital executives from the participating states attended the conference. W. C. Bloxom, president-elect of the Virginia Hospital Association and administrator of the Johnston-Willis Hospital at Richmond, was named president of the conference for 1959.

William R. Huff, executive secretary of the West Virginia Hospital Association, became the first permanent executive secretary of the conference.

Commenting on progressive care, Dr. McGuinness said in his address to the conference that these plans constitute "one approach to solution of the cost problem—costs to the patient, to the hospital, and to the insurer."

There are indications that self-service units for ambulatory patients can be operated at much lower expense than regular hospital units, Dr. McGuinness said. "Since the cost of services alone makes up about 70 per cent of all hospital costs, any time a hospital can eliminate services safely it can reduce charges," he pointed out. "We must explore every possibility for arresting the upward trend in the cost of medical care if we are to expect insurance carriers and prepayment plans to come up with broader coverage at premiums which most people can afford to pay."

The answer to the problem of the hospital trustee is the hospital administrator, Harry R. Stephenson Jr., chairman of the board of trustees of the Greenville General Hospital, Greenville, S.C., told the conference. It is possible to systematize the hospital program so that in almost every area of responsibility the authority of the board and the administrator is precisely outlined and understood, Mr. Stephenson said.

"We are agreed that both legally and morally the board is totally responsible for the entire operation," he explained. "However, to carry out this responsibility on an active, day-to-day basis, the duties of internal operation are totally delegated to the hospital director, with certain prerogatives retained by the board."

Once a year at Greenville, Mr. Stephenson said, the board sits in review on a proposed operational program for the entire year, presented in full detail, department by department.

"As it is presented, the board approves the program, or parts of it, and grants the authority to get it

(*Continued on Page* 152)

Public Unduly Fears Chest X-Ray, Doctor Says

CHICAGO.—Recent "radiation hysteria" has made many Americans unduly afraid of routine chest x-rays at a time when such x-rays are more important than ever, medical students were told here last month.

Speaking to the Student American Medical Association, Dr. Theodore H. Noehren of Buffalo, N.Y., said the chest x-ray remains the outstanding laboratory method for finding and diagnosing chest diseases and that the need for a chest x-ray in many cases far outweighs the danger, and its accompanying fear, of slight radiation.

Blue Cross Commission Names Garside Chairman, Gives van Steenwyk Award

CHICAGO.—Charles Garside, board chairman and president of Associated Hospital Service of New York, was named chairman of the Blue Cross Commission, succeeding Robert T. Evans of Chicago, at the annual conference of Blue Cross plans here last month.

Mr. Evans is executive director of the Chicago Blue Cross plan.

E. A. van Steenwyk, executive director of the Associated Hospital Service of Philadelphia, became the first man ever to receive a formal award for "outstanding encouragement given to the concept of prepaid voluntary health care plans."

The first annual award, a medal and certificate, honors the memory of Justin Ford Kimball, founder of the first health prepayment plan in Dallas, Tex. From 1941 to 1955, Mr. van Steenwyk served as the first chairman of the Blue Cross Commission.

A record $1,210,591,526 was paid to hospitals by Blue Cross for patient care last year, Mr. Evans reported to the conference. More than 2 million new members joined the organization, bringing the membership to nearly 56 million.

According to the annual report, Mr. Evans said, on a national basis Blue Cross plans paid more for hospital care for members than was received in subscriber income last year. During 1957, he said, more than $8 million was removed from reserve funds to meet the difference between what subscribers paid and the actual cost of members' hospital care.

Also named commission officers were: vice chairman, H. Charles Abbott, executive director, Hospital Service of Southern California, and treasurer, Walter R. McBee, executive director, Group Hospital Service, Inc., Dallas, Tex. Dr. Kenneth B. Babcock, director of the Joint Commission on Accreditation of Hospitals, remains on the commission's executive committee. William S. McNary, executive vice president of the Michigan Hospital Service, Detroit, was elected as a new member of the executive committee.

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Michigan Blue Cross Puts Ceiling on Payments to Hospitals, Forestalls Subscriber Rate Hike

DETROIT.—To forestall an increase in Blue Cross rates, Blue Cross payments to Michigan hospitals in 1958 will be held to a maximum of 104 per cent of the hospitals' cost per patient day in 1957, it was announced last month.

In addition, regardless of whether a hospital's cost in 1958 reaches the 104 per cent ceiling, final Blue Cross payments to all its participating hospitals will be cut an additional 1 per cent, William S. McNary, executive vice president of the Michigan Blue Cross plan, said.

Hospitalization payments hit 101.57 per cent of total income during the first three months of 1958 and sent the plan more than $1.6 million in the red, Mr. McNary said. The deficit reduced the plan's reserves to $5.4 million by March 31, he stated.

The ceiling on 1958 payments was adopted on recommendation of a majority of the plan's member hospitals and is a temporary measure, Mr. McNary explained. A special committee of the Blue Cross board of trustees will begin to seek a long-range solution to the plan's financial problem.

The Michigan Hospital Association has urged its members to cooperate with Blue Cross. Ralph Hutchins, president of the association, said:

"It is no exaggeration to say that while the action of the board of trustees of Blue Cross was necessary and apparently the most equitable one, the outstanding rate of progress shown by Michigan hospitals in the past decade will be profoundly and adversely affected.

"It would be wrong for the public to assume that Michigan hospitals can really afford this cut-back in their Blue Cross payments and at the same time continue to keep abreast of the latest advances in medical science.

"It is quite likely, however, that our hospitals can, despite the Blue Cross payment ceiling, maintain their present high standard of patient care temporarily."

Georgia Blue Cross Plan Wins Increase in Rates

ATLANTA, GA.—At a precedent setting public hearing May 9 before Insurance Commissioner Zack D. Cravey, the application for additional benefits and increased fees by the Georgia Hospital Service Association, Columbus (the Blue Cross plan serving 119 Georgia counties), was ordered approved.

The increase in monthly fees of Blue Cross members served by the plan averages 18 per cent for group members and 12 per cent for nongroup members. The increases were expected to become effective on June 1 for nongroup members and on July 1 for groups.

No one appeared at the hearing in opposition to the application, which affects Blue Cross members in all parts of the state except the area surrounding Atlanta and Savannah.

Sam M. Butler, executive director of the plan, which has more than 150,000 Georgians enrolled, led the support of the application for the rate increase and additional benefits. In a comprehensive, 43 page presentation, Mr. Butler outlined the financial condition of the plan and the threefold reason for the additional rates.

"Basically, the problem facing our plan is the fact that Blue Cross is paying out more money in claims than it is receiving in subscription fees," Mr. Butler said. He explained further that during the last 12 months the plan has been paying out $1.15 for each dollar of income it has received. He said that during this same period the plan had lost more than $158,000.

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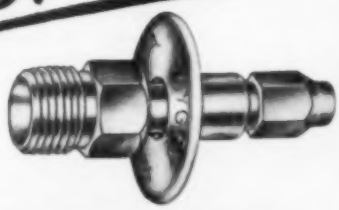

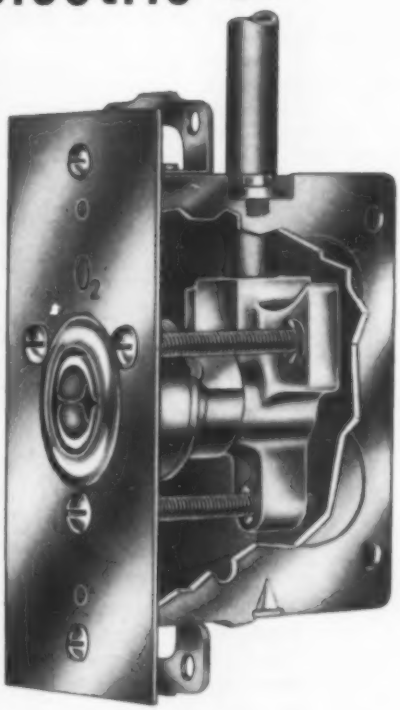

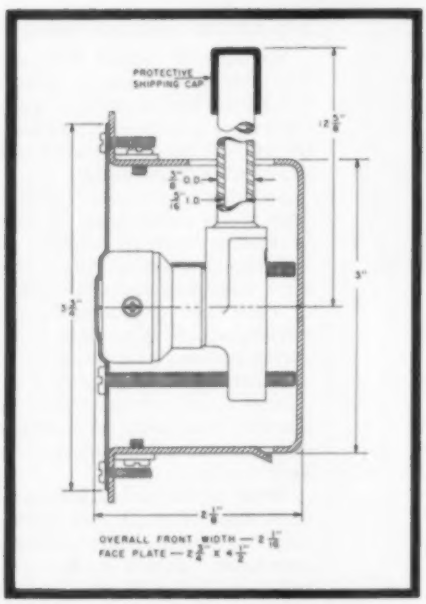

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Government to Play Increasing Rôle in Hospitals, Frank S. Groner Tells Southeastern Delegates

MIAMI, FLA.—Hospital people can be sure that government at all levels will play an increasing rôle in the hospital system in the future, Frank S. Groner, president of the American College of Hospital Administrators, said here last month.

Mr. Groner spoke to delegates of the 21st annual Southeastern Hospital Conference, held at the Hotel Fontainebleau May 14 to 16. Approximately 1730 persons attended the convention and allied group meetings.

Governments will probably have to pick up where voluntary prepayment plans leave off, Mr. Groner said, discussing "The Hard Facts of Hospital Financial Operations."

"As more people need and seek our services, we dip deeper into that portion of society which finds payment for hospital services very difficult," he commented.

"The day is past when we can expect hospital employes to work longer hours and at much lower pay rates per hour than workers in other fields," Mr. Groner cautioned the delegates.

Although hospitals generally have good over-all management and many of our departments are excellently managed, we have not been so successful in providing efficient operation of nursing departments, said Lester E. Richwagen, administrator of Mary Fletcher Hospital, Burlington, Vt.

More and more R.N.'s must become skilled in leadership and management, Mr. Richwagen said. In most hospitals, merely increasing the number of nursing personnel not only does not improve care, but actually adds to the administrative problems, he noted.

He advocated short courses in management and supervisory technics for groups of nurses selected for their inherent supervisory abilities and their interest in leadership and management.

"In doing so, we can greatly help our head nurses and supervisors to feel much more comfortable with their responsibilities," he said.

EVALUATING NURSING NEEDS

Apollonia O. Adams, R.N., chief of the division of nursing resources of the Public Health Service, presented a paper on evaluation of nursing service needs by means of studies of activities of nursing personnel.

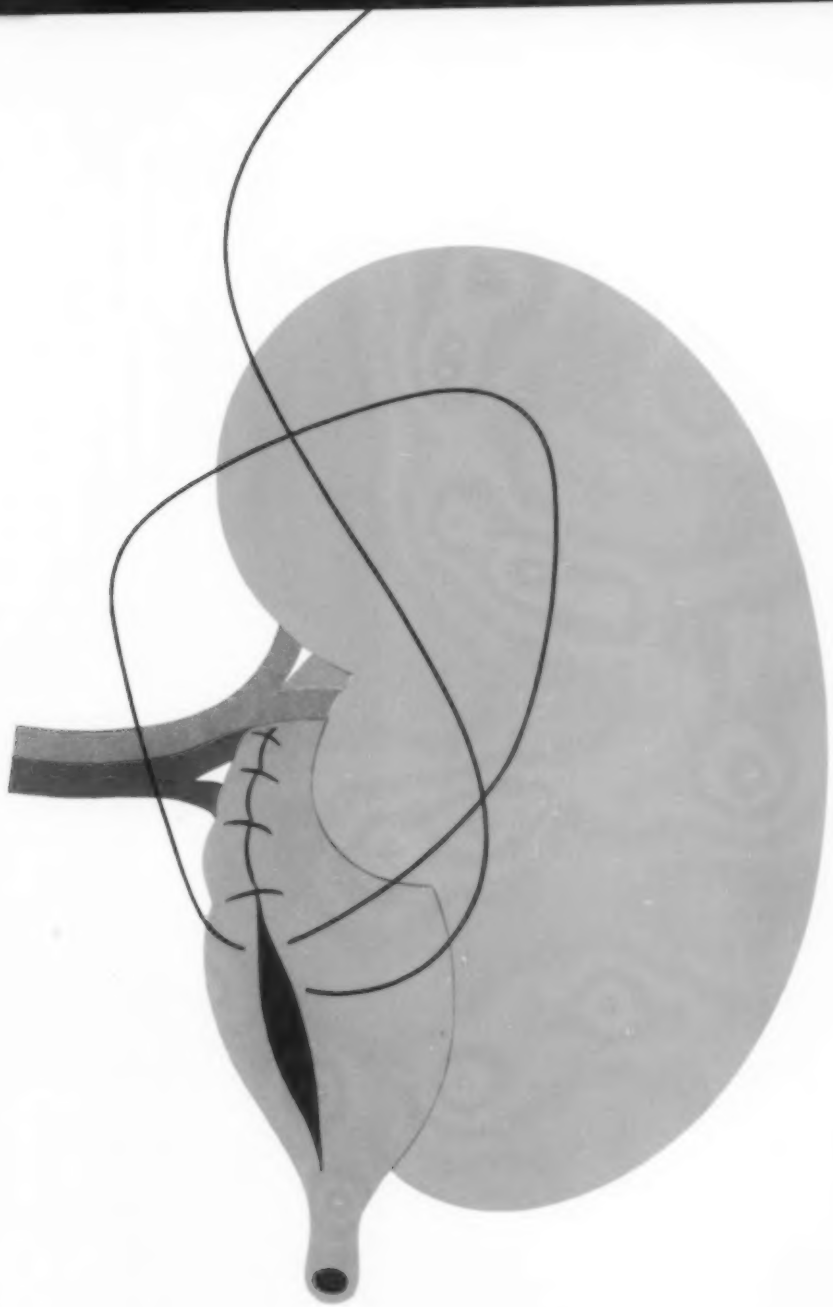
To date, the division of nursing resources has aided some 70 hospitals in making nursing activity studies, with reassignment of duties, hiring of ward managers, and clerks, changing of some nursing procedures, and establishment of other time and labor saving technics as a result.

Following the presentation of Miss Adams' paper, representatives of four hospitals commented on changes made in their nursing departments following such studies.

Oscar S. Hilliard, administrator of Tri-County Hospital, Fort Oglethorpe, Ga., was named president-elect of the association. Robert A. Ivy, administrator of Doster Hospital and Clinic, Columbus, Miss., was installed as president, succeeding Pat N. Groner, administrator of Baptist Hospital, Pensacola, Fla.

George Burt, administrator of Piedmont Hospital, Atlanta, Ga., was named vice president.

Directors are the presidents of state associations affiliated with the conference, as follows: Alabama, E. E. Cavaleri Jr.; Florida, Steve McCrimmon; Georgia, Millard Ware; Louisiana, Freeman May; Mississippi, Dr. David B. Wilson; Tennessee, William Barnhart. Member at large is Herman L. Herold, administrator of North Louisiana Sanitarium, Inc., Shreveport.



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New Jersey Supreme Court Overturns Doctrine of Immunity for Charities

TRENTON, N.J.—By a 5 to 2 decision, the New Jersey Supreme Court ruled April 28 that religious and charitable institutions, including nonprofit hospitals, can be sued and held liable for negligence.

The ruling was based on three cases before the court, including a $100,000 suit against the Newark Eye and Ear Infirmary. William S. Collopy of Nutley had charged the infirmary was negligent when he fell out of bed and injured himself. He said his eyes were bandaged after an operation when the mishap occurred.

Two other suits involved a Catholic church and a Y.M.C.A.

Justice Nathan L. Jacobs said in the majority opinion that the theory that charitable trusts are immune from suits for negligence, because any judgment against the trusts would thwart the wishes of the donors, had "no merit" insofar as common law was concerned.

"Due care is to be expected of all, and when an organization's negligent conduct injures another there should, in all justice and equity, be a basis for recovery without regard to whether the defendant is a private charity," Justice Jacobs said. The immunity doctrine, he added, "operates harshly and disregards modern concepts of justice and fair dealing."

Administration Students at St. Louis University Assigned to Residencies

ST. LOUIS.—Residency appointments in hospital administration have been announced for students in the graduate course at St. Louis University, as follows:

Sister Myra James, Bradley, S.C., to Good Samaritan Hospital, Cincinnati; Robert E. DeBacker to Santa Rosa Hospital, San Antonio, Tex.; Sister Mary Grace Dougherty, O.S.F., to St. Francis Hospital, Hartford, Conn.; Sister M. Raymond Ellison, S.P.S.F., to St. Vincent Charity Hospital, Cleveland; Sister Mary Annella Foelker, C.D.P., to O'Connor Hospital, San Jose, Calif.

Sister M. Ursula Frei, S.C.C., to St. Joseph's Hospital, Philadelphia; Sister M. Amadeus Friel, S.S.J., to Good Samaritan Hospital, Dayton, Ohio; Sister Rose Vincent Gleason, O.S.F., to Good Samaritan Hospital, Cincinnati; Sister M. Aileen Griffin, O.S.F., to Sisters of Charity Hospital, Buffalo, N.Y.; Sister Mary Kieran Harney, R.S.M., to Sacred Heart Hospital, Yankton, S.D.

Sister Olivia Marie Hutcheson, C.S.C., to St. Vincent's Hospital, New York; Sister M. Consolata Kline, H.H.M., to St. Vincent's Hospital, New York; Sister Mary Agnes Koenig, O.P., to Holy Cross Hospital, Salt Lake City; Sister Mary Venarda Lance, R.S.M., Firmin-Desloge Hospital, St. Louis; Sister Mary Eva Loyacono, R.S.M., to St. Vincent's Hospital, Birmingham, Ala.

Sister M. Leonella Lynch, I.H.M., to St. Mary's Hospital, San Francisco; Sister Mary Euphrasia Markham, O.S.F., to Holy Name Hospital, Teaneck, N.J.; Sister Mary Walter Meagher, R.S.M., to Loretto Hospital, Chicago; Sister Mary Urban Mehring, R.S.M., to St. Joseph's Hospital, Phoenix, Ariz.; Sister Mary Edwardine Neumeyer, R.S.M., to St. Charles Hospital, Toledo, Ohio; Melvin C. Nicholson to City Hospital, St. Louis.

Sister Anthony Marie Phillips, C.S.J., to St. Mary's Hospital, San Francisco; Orlando R. Pozzuoli to St. Elizabeth's Hospital, Youngstown, Ohio; Sister Mary Joan Redmann, O.P., to St. Dominic-Jackson Memorial Hospital, Jackson, Miss.; Sister M. Sylvia Schuler, O.S.F., to Genessee Hospital, Rochester, N.Y.; Sister M. Rita Sparber, O.S.B., to St. Mary's-Corwin Hospital, Pueblo, Colo.; Sister Mary Francis Stubbs, S.C.L., to St. Francis Hospital, LaCrosse, Wis.

Sister Mary Ellen Sullivan, unassigned; Roy W. Thornton to City Hospital, St. Louis; Francis P. Weston to St. Mary's-Corwin Hospital, Pueblo, Colo.; Sister M. Bernardine Wild, C.D.P., to St. Francis Hospital, LaCrosse, Wis., and Sister M. Coronata Wolf, S.P.S.F., to St. Joseph's Mercy Hospital, Pontiac, Mich.

Conference Recommends Immediate Listing of Nursing Homes by A.H.A.

(*Continued From Insert op.* 49)

all the groups that numerous studies should be made of facilities now providing care for the long-term patient, their financing, staffing, plant and programs.

Group IV, chaired by J. Douglas Colman of the Blue Cross Association, however, suggested that "too many studies are made as of a point of time. We would like to see the studies consider change and the rate of change," he reported for his discussion group.

Dr. Michael M. Dacso, director of the department of physical medicine and rehabilitation of the Goldwater Memorial Hospital of New York, spoke for Group II on question B, involving publications the A.H.A. might publish for nursing homes.

Holding that such publications are an A.H.A. responsibility, Group II recommended guides in these areas:

1. The relationships among the various health institutions, covering what the relationships are and what they should be.

2. Standards of professional care for nursing homes and similar institutions.

3. Standards of staffing which would include the duties of the staff, admission and discharge policies and transfer policies.

4. Development and maintenance of standards for physical facilities, which would involve community planning, finance and staff.

Other groups seconded this report, adding the suggestions that a pilot plan precede any large-scale publication program and that the relationship of the family and the family physician to the institution for long-term care be considered.

Dr. David Littauer, executive director of Jewish Hospital of St. Louis, was chairman of Group III, which considered question C on the subject of how to develop optimum relationships between hospitals and other facilities.

He stated that the hospital has the primary responsibility in fostering local cooperation and added that the individual hospital administrator should initiate such action.

It was in considering this question that a new A.H.A. research trust term, para-hospital, was introduced. This term, describing an institution rendering a medically oriented service, was tentatively defined as "an inpatient center with the continuous services of nurse's aides or the equivalent who are supervised by a registered nurse or licensed practical nurse or the equivalent who in turn is under the direction of a physician."

It was recommended that: Hospitals and their medical staffs should take the lead in developing area cooperation between hospitals and para-hospitals; continuity of care is an ideal to be gained by including para-hospitals and hospitals in any community in one administrative unit, and hospitals should make their facilities available to para-hospitals.

Group I suggested that the initial plan to bring para-hospitals under a single administrative unit with hospitals might well be negotiated by a third party, such as a state department or association.

That para-hospitals hesitate to accept patients from hospitals for fear the hospitals will refuse to readmit the patient if he develops a short-term illness while a nursing home patient was brought out. It was suggested that the cooperation of the medical society is vital to prevent such disagreements.

Question D, which took up listing in considering an A.H.A. program of service, was the primary concern of Group IV.

The para-hospital which would be listed by the A.H.A. if this group had its way would meet these criteria:

It would be licensed by the state, it would have a physician on the staff, it would have each patient under the care of a physician, it would main-

tain a medical record for each patient, it would provide nursing care with a registered nurse on duty at all times, it would have at least 6 beds for patients, and it would serve menus planned in advance and approved by a dietitian or a doctor.

They further recommended that a para-hospital meeting these criteria would be admitted to full membership in the A.H.A. Group I concurred for the most part with Group IV's findings.

Group II, while holding that listing is an end which the A.H.A. should work toward—and urgently—said that listing would do no good at this time.

Questioned on Group II's objection, Chairman Dacso called on J. Milo Anderson, administrator of Strong Memorial Hospital, Rochester, N.Y., for support. Mr. Anderson said the group felt that only a negligible number of nursing homes would meet any criteria that the A.H.A. might establish and the result would be not to upgrade para-hospitals generally, but only to recognize the few which would meet listing requirements.

Asked if the decision was unanimous, Dr. Dacso said no poll of the group had been taken, but that no member of the unit had objected to the report.

The report of the conference will be typed and submitted to the parent bodies.

Seattle Hospital Strike Moves Into Third Month as Negotiations Hit Snag

SEATTLE.—The strike of members of Hospital Workers Union, Local 301, against Swedish Hospital moved into its third month here with no settlement of the dispute in sight.

The wave of violence and harassment that had plagued the hospital and disturbed patients for several weeks apparently had come to an end, however. Pending was trial of an official of an affiliated union who had admitted responsibility for some of the hoodlumism.

Still pending, also, was disposition of a union attempt to obtain federal intervention. The strikers sought this after negotiations, which for a time had seemed to be nearing an agreement, were broken off.

Major development of the past month was the admission of James Pritchett, business agent and organizer for Local 23, Window Cleaners Union, which is not on strike against the hospital, that he was responsible for the discharge of fireworks around the hospital and at the home of its administrative personnel.

Pritchett was charged in justice of the peace court with illegal possession of gas (stench) bombs, after detectives, acting on an anonymous tip, found firecrackers, "torpedoes" and home-made stench bombs in his home.

The charge was filed while Pritchett was a patient in another hospital, Ballard General, with a kidney ailment. Bond of $3000 was requested.

Members and leaders of the striking union were not involved in the harassment and had no knowledge of it, Pritchett said.

Prior to Pritchett's arrest, the strike had entered a period of quiet, although pickets still patrolled the hospital entrances 24 hours a day.

Earlier, in meetings arranged by the labor council, the hospital and the union at one point had seemed close to agreement on a settlement.

It is reported that the proposed settlement would have provided for an end to the picketing and for the placing of all but 17 of the 87 strikers on a priority list for reemployment at the hospital.

Some would have been returned to their jobs immediately, others as openings occurred. The hospital, however, had refused to rehire 17 of those on strike. The union refused to accept a settlement on this basis, and negotiations were broken off.

Raymond F. Farwell, Swedish Hospital administrator, left for a three-week vacation which the strike had postponed, and negotiations were stalled until his return.

Speaker Urges Hospitals to Develop Team to Meet Patients' Emotional Needs

DES MOINES, IOWA. — Hospitals should develop a patient care team to look after the emotional needs of patients, delegates to the Iowa Hospital Association meeting were told recently.

Raymond P. Sloan, chairman of the editorial board of The MODERN HOSPITAL, recommended that such a team include representatives of the administration, medical and nursing staffs, housekeeping and dietary departments, social service, the hospital auxiliary, and particularly, the clergy. It might also include a psychologist or psychiatrist, he said.

American hospitals provide the finest medical attention in the world, Mr. Sloan said, but they must recognize more fully that the emotional needs of the patients are related closely to the physical needs.

The patients should be informed fully before entering the hospital and then should have "follow-through" help upon returning home after surgery or serious hospitalization, he stated.

Hospital leaders should concentrate on the importance of the patient, he urged. "After all, the only reason for the existence of hospitals is the patient," he commented.

Hospital representatives attending the annual Blue Cross plan meeting, held concurrently in Des Moines, were told that a record number of Iowans were admitted to hospitals in 1957, with hospital costs reaching an all-time high.

F. P. G. Lattner, executive director of the plan, reported that the $15 million paid in 1957 for members' hospitalization represented a 16 per cent increase over 1956.

CHOOSE NEW OFFICERS

Thomas E. Frey, administrator of Allen Memorial Hospital, Waterloo, was named president-elect of the association. James A. Anderson, administrator of Lutheran Hospital, Fort Dodge, was installed as president.

Other officers are: first vice president, James L. Dack, administrator of Methodist Hospital, Sioux City; second vice president, Donald L. Plunkett, business manager of Mercy Hospital, Council Bluffs, and treasurer, Paul H. Keiser, administrator of Burlington Hospital, Burlington.

Trustees are Donald W. Cordes, administrator of Iowa Methodist Hospital, Des Moines, and Sister Mary Maurice, administrator of St. Joseph Sanitarium, Dubuque. Delegate to the A.H.A. is Leon A. Bondi, administrator of St. Luke's Hospital, Davenport.

Architects, Henry D. Dagit & Sons, Philadelphia, Pa., selected tan mottle "8W Series" Natco vitritile to achieve a warm low brightness in the snack bar of Villanova University's Student Union Building. Note vitritile enclosed recess for automatic folding door at center left. General Contractor was Joseph R. Farrell Inc., Philadelphia. Masonry Contractor was John B. Kelly Inc., also of Philadelphia.

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St. Barnabas Center Plans 400 Bed Hospital Around Progressive Care Concept

NEWARK, N.J. — Ground breaking ceremonies for a new St. Barnabas Medical Center, a $10 million, 400 bed institution designed to group patients according to medical need, took place here last month.

Patient areas will include an admission area for preoperative diagnostic cases, an intensive care unit, where all surgical patients will go after leaving the recovery room, and a convalescent area.

Advantages include: (1) lessening of apprehension for newly admitted patients, since they will see no acutely ill or postoperative patients in the admitting area; (2) conserving of the time and energy of patients and personnel since services are grouped around the nursing floor.

Admission area, intensive care unit, operating, cystoscopic and fracture rooms, recovery room, clinical and x-ray laboratories, and outpatient and rehabilitation departments are all on the ground floor.

The maternity and pediatric departments will occupy separate floors.

Other professional services include research laboratories, various types of medical "banks," a poison control unit, a trauma team, and a rehabilitation center.

A 100 bed building for geriatric and long-term ambulatory patients also is included in the planning. This building will be of a motel type with all facilities on one floor, connected to the main hospital by an enclosed walk or a tunnel.

Resident facilities will be provided for professional personnel.

Other features of the hospital are an educational museum, an auditorium with closed-circuit television for educational purposes and community health and disaster meetings, classrooms, a cafeteria, a 1000 car parking area, gift shop, flower shop, library service, and personal service shops. The center is scheduled for completion in 1959-60. Architects are Ferrenz and Taylor, New York.

Massachusetts Group Installs Msgr. Dalton as Association President


Rt. Rev. Msgr. A. C. Dalton

BOSTON. — R. Ashton Smith, director of Lawrence General Hospital, Lawrence, Mass., was named president-elect of the Massachusetts Hospital Association at the group's 22d annual meeting here May 15.

Rt. Rev. Msgr. A. C. Dalton, director of Catholic hospitals for the Archdiocese of Boston, was installed as president.

Bertrand B. Nutter, director of Salem Hospital, Salem, was chosen treasurer. Trustees for four years are Harold L. Hutchins Jr., director of Pittsfield General Hospital, Pittsfield, and Richard Bullock, directing trustee of Burbank Hospital, Fitchburg. Haydn M. Deaner, administrator of Truesdale Hospital, Fall River, was named a trustee for the year ending in 1959.

NOTICE TO READERS

Before you send to the binders your copies of the 1958 issues of The Modern Hospital, you will want a copy of the index to each volume. The index to Volume 90 (January to June) may be obtained by addressing a postcard or letter requesting a copy to The Editor, The Modern Hospital, 919 North Michigan Avenue, Chicago 11, Ill. There is no charge. Those persons who have previously written for the index to Volume 89 (July to December 1957) will be sent the latest index without further correspondence.

Progressive Patient Care Outlined at Meeting of Carolinas-Virginias

(*Continued From Page* 140)

done," he said. In addition, the board periodically reviews and critically evaluates the failures and accomplishments of the management group in the achievement of these objectives.

The program at Greenville is divided into five areas of responsibility: finances, planning, community and governmental relations, medical staff relations, and internal operations.

"In order to follow through our approval and our review and evaluation programs, the board is organized into committees on the basis of these areas of responsibility," he said. "The first meetings of the committees at the beginning of the year are given over to reading, reviewing, discussing and accepting or rejecting the proposed objectives that are pertinent to the committee. Subsequent meetings are held to review and evaluate progress. In the interim, the entire board is apprised by the proper committee of the progress being made, the problems that exist, and the action necessary to overcome the problems.

"The kind of program we have undertaken takes the guesswork out of our board operation. We know we are responsible; we ask the director to tell us what he hopes to achieve during the year; we review his proposals and approve them if they are reasonable. Then we grant him the authority to carry them out, evaluate his progress and judge his accomplishments."

In the area of medical staff relations, the board cannot delegate the responsibility for appointment, termination of appointment, or punitive or disciplinary action, Mr. Stephenson said.

"Hospital management is changing," he concluded. "There is a trend toward adopting the systems and sciences of administration for application in the hospital setting. In the five major areas of responsibility, the board can delegate responsibility and authority for the internal operation of the hospital, but it can properly do so only if an intelligent program has been presented and adopted. When this is not done, it is inevitable that the board will, in trying to protect its trust, 'interfere' with the operation of the hospital and will indulge in operational detail to the despair of the director. If this happens, it is the fault of the administrator, for he has not provided the board with the operational plan he hopes to follow, and they cannot abdicate their trust."

Texas Hospital Group Installs W. P. Earngey as 1958-59 President

DALLAS, TEX.—W. P. Earngey Jr., administrator of Harris Hospital, Fort Worth, was installed as president of the Texas Hospital Association, succeeding Dr. Bolton Boone, administrator of Methodist Hospital, Dallas, at the annual convention May 5 to 8.

Approximately 2500 delegates attended the convention, at which Ray M. Amberg, president-elect of the A.H.A.; Frank S. Groner, president of the American College of Hospital Administrators; Dr. Robin C. Buerki, executive director of Henry Ford Hospital, Detroit, and James A. Hamilton, director of the University of Minnesota hospital administration course, were the featured speakers.

CORRECTION

The pictures of the air conditioning installation at North Carolina Baptist Hospital, Winston-Salem, which appeared on pages 106 and 108 of the April issue of The MODERN HOSPITAL, should have been credited to the Carrier Corporation.

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Colorado State College	Greeley, Colo.	R. F. Linstedt–Denver, Colo.
*Cuyahoga County Hospital	Warrensville Township, O.	Horn & Rhinehart–Cleveland, O.
Holzer Hospital–Nurses' Residence	Gallipolis, O.	Dan A. Carmichael, Jr.–Columbus, O.
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Marshall College	Huntington, W. Va.	C. E. Silling–Charleston, W. Va.
Memorial Hospital of DuPage County	Elmhurst, Ill.	Schmidt, Garden & Erikson–Chicago, Ill.
Morehead State College	Morehead, Ky.	George Lusk–Ashland, Ky.
*Morris Harvey College	Charleston, W. Va.	Charles A. Haviland–Charleston, W. Va.
Oberlin College–Women's Dorm.	Oberlin, O.	Potter, Tyler, Martin & Roth–Cincinnati, O.
Oberlin College–Men's Dorm.	Oberlin, O.	Potter, Tyler, Martin & Roth–Cincinnati, O.
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Rio Grande College	Rio Grande, O.	C. M. Donaldson–Portsmouth, O.
St. Luke's Nurses Home	Saginaw, Mich.	Schmidt, Garden & Erikson–Chicago, Ill.
University of So. Carolina	Columbia, S. C.	Lyles, Bissett, Carlisle & Wolff–Columbia, S. C.
*Southern Methodist University Men's Dormitory	Dallas, Tex.	George L. Dahl–Dallas, Tex.
*Southern Methodist University Women's Dormitory	Dallas, Tex.	George L. Dahl–Dallas, Tex.
Stevens Institute of Technology	Hoboken, N. J.	Voorhees, Walker, Smith & Smith–New York City
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Babcock Discusses Job of Hospital Administrator

CHICAGO.—Accidents which might have been prevented by proper control of medical standards will bring on an increasing number of malpractice suits, which hospitals and doctors will increasingly lose, a group of hospital administrators and students was warned last month.

Speaking to members of Alpha Delta Mu, hospital administration fraternity, Dr. Kenneth Babcock discussed administrative responsibilities, including the legal side of medicine. While pointing out that the hospital, through its trustees, must govern and control medical practice of the staff in the hospital, he cautioned administrators to avoid continuously looking over their shoulders to see whether they were going to be sued. "If you do so, you will not be a good administrator," he commented.

Dr. Babcock also pointed out the responsibility of administrators, medical staff, and trustees in combating hospital infections. Hospitals have put too much faith in antibiotics and have forgotten to do efficient, old-fashioned scrubbing and cleaning, he noted.

Dr. Babcock was awarded an honorary membership in the fraternity. President is Paul Kempe, administrator of Silver Cross Hospital, Joliet, Ill.

THE BOOK SHELF

LESSONS IN GOOD HOUSEKEEPING. *Emily C. Deming. Copies are available from Miss Deming, who is executive housekeeper, Butterworth Hospital, Grand Rapids 3, Mich. $3, postpaid.*

The lessons in housekeeping technic, which were first printed in THE MODERN HOSPITAL, follow the outline of instruction given to hospital personnel at Butterworth Hospital by Miss Deming. Chapters on orientation and introduction to the hospital and housekeeping begin the lessons, followed by material on equipment and supplies.

The basic technics of sweeping, mopping, machine scrubbing, waxing and dusting are discussed. Chapters on window washing and maintenance and on the sewing room are included. Housekeeping employes are taught how to prepare a patient's room and various safety practices.

The book also includes illustrations of housekeeping technics and equipment, vacation schedules, work schedules, personal appearance reminders, and a graduation certificate.

COMING EVENTS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Statler Hotel, Boston, Oct. 13-16.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Institutes: 8th New York, New York, June 23-27; 8th Western, Palo Alto, Calif., June 23-27; 26th Chicago, University of Chicago, Sept. 2-12; 9th Chicago Advanced, University of Chicago, Sept. 8-12.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Members Conferences: Region 11, Kansas City, Mo., Oct. 20-24; Region 10, Minneapolis, Oct. 27-31; Region 1, Boston, Nov. 10-14; Region 8, East Lansing, Mich., Nov. 17-21. Annual Meeting and Convocation, International Amphitheater and Orchestra Hall, Chicago, Aug. 16-18.

AMERICAN DIETETIC ASSOCIATION, Bellevue Stratford and Benjamin Franklin Hotels, Philadelphia, Oct. 21-24.

AMERICAN HOSPITAL ASSOCIATION, convention, Palmer House, International Amphitheater, Chicago, Aug. 18-21.

AMERICAN NURSES' ASSOCIATION, Convention Hall, Atlantic City, N.J., June 9-13.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Statler Hotel, Boston, Oct. 26-29.

AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS, Schroeder Hotel, Milwaukee, June 15-20.

ARIZONA HOSPITAL ASSOCIATION, Westward-Ho Hotel, Phoenix, Nov 13, 14.

ARKANSAS HOSPITAL ASSOCIATION, Arlington Hotel, Hot Springs, May.

BRITISH COLUMBIA HOSPITALS' ASSOCIATION, Hotel Vancouver, Vancouver, Oct. 28-31.

CALIFORNIA HOSPITAL ASSOCIATION, Biltmore and Miramar Hotels, Santa Barbara, Oct. 22-24.

CATHOLIC HOSPITAL ASSOCIATION, Atlantic City, N.J., June 21-26.

COLORADO HOSPITAL ASSOCIATION, Cosmopolitan Hotel, Denver, Oct. 9, 10.

COMITÉ DES HÔPITAUX DU QUEBEC, Montreal Show Mart, Montreal, Que., June 25-27.

CONNECTICUT HOSPITAL ASSOCIATION, Berlin Light and Power Co., Berlin, June 11.

HOSPITAL ASSOCIATION OF RHODE ISLAND, Sheraton-Biltmore Hotel, Providence, Oct. 21.

IDAHO HOSPITAL ASSOCIATION, Elks Temple, Boise, Oct. 20, 21.

INDIANA HOSPITAL ASSOCIATION, Indiana Student Union Building, Indianapolis, Oct. 8, 9.

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 13, 14.

MAINE HOSPITAL ASSOCIATION, Samoset Hotel, Rockland, June 10, 11.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, D.C., Nov. 3-5.

MICHIGAN HOSPITAL ASSOCIATION, Grand Hotel, Mackinac Island, June 17, 18.

MINNESOTA HOSPITAL ASSOCIATION, Lowry Hotel, St. Paul, Nov. 7.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Heidelberg, Jackson, Oct. 23, 24.

MISSOURI HOSPITAL ASSOCIATION, President Hotel, Kansas City, Nov. 19-21.

MONTANA HOSPITAL ASSOCIATION, Havre, Sept. 15, 16.

NEBRASKA HOSPITAL ASSOCIATION, Omaha, Oct. 23, 24.

OKLAHOMA HOSPITAL ASSOCIATION, Skirvin Hotel, Oklahoma City, Nov. 6, 7.

OREGON ASSOCIATION OF HOSPITALS, Gearhart Hotel, Gearhart, Oct. 13, 14.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Roanoke, Roanoke, Nov. 14-16.

WASHINGTON STATE HOSPITAL ASSOCIATION, Winthrop Hotel, Tacoma, Oct. 15, 16.

WEST VIRGINIA HOSPITAL ASSOCIATION, Daniel Boone Hotel, Charleston, Oct. 15-18.

1959

ALABAMA HOSPITAL ASSOCIATION, Admiral Semmes Hotel, Mobile, Jan. 23, 24.

ASSOCIATION OF WESTERN HOSPITALS, Hotel and Motel Utah, Salt Lake City, May 4-7.

Washington Hospitals Use Lobby Displays for Public

WASHINGTON, D.C. — Hospitals in the Washington, D.C., area and in Delaware observed National Hospital Week, May 8 to 14, by using lobby exhibits to interest the public in hospital work, it was reported.

Theme of this year's displays was "Women in Medicine." The exhibits were prepared by the Medical Museum of the Armed Forces Institute of Pathology, under the direction of Helen R. Purtle, assistant curator.

In previous years, the presentations have included displays of Chinese treatment instruments, early stethescopes, and other medical equipment.

The Need Was Great... but the Opposition Was Strong and then They Called The American City Bureau

This was the Problem... Niagara Falls Memorial Hospital was faced with a shortage of beds, obsolete equipment *and* growing demands on its services.

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The Result . . . Goal—$1,346,667 Raised—$1,427,822. Under Bureau direction, Niagara Falls Memorial Hospital's goal was surpassed by $81,215. In addition, the hospital now enjoys greater good will than ever before among doctors, industry, labor and the community's citizens.

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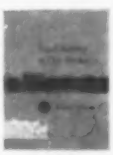


FOUNDING MEMBER AMERICAN ASSOCIATION OF FUND-RAISING COUNSEL

ABOUT PEOPLE

(*Continued From Page 80*)

E. Grey Gooby

E. Grey Gooby has been appointed assistant director of the General Hospital of St. Luke's Hospital, New York. For the last five years, Mr. Gooby has been administrative assistant of Pennsylvania Hospital, Philadelphia. He is a graduate of the master's degree program in hospital administration at Columbia University.

William G. Nelson has taken up his duties as administrator of the new Putnam Memorial Hospital, Palatka, Fla. He was administrator of Bradley Memorial Hospital, Cleveland, Tenn., for more than four years.

Frederick W. LaCava

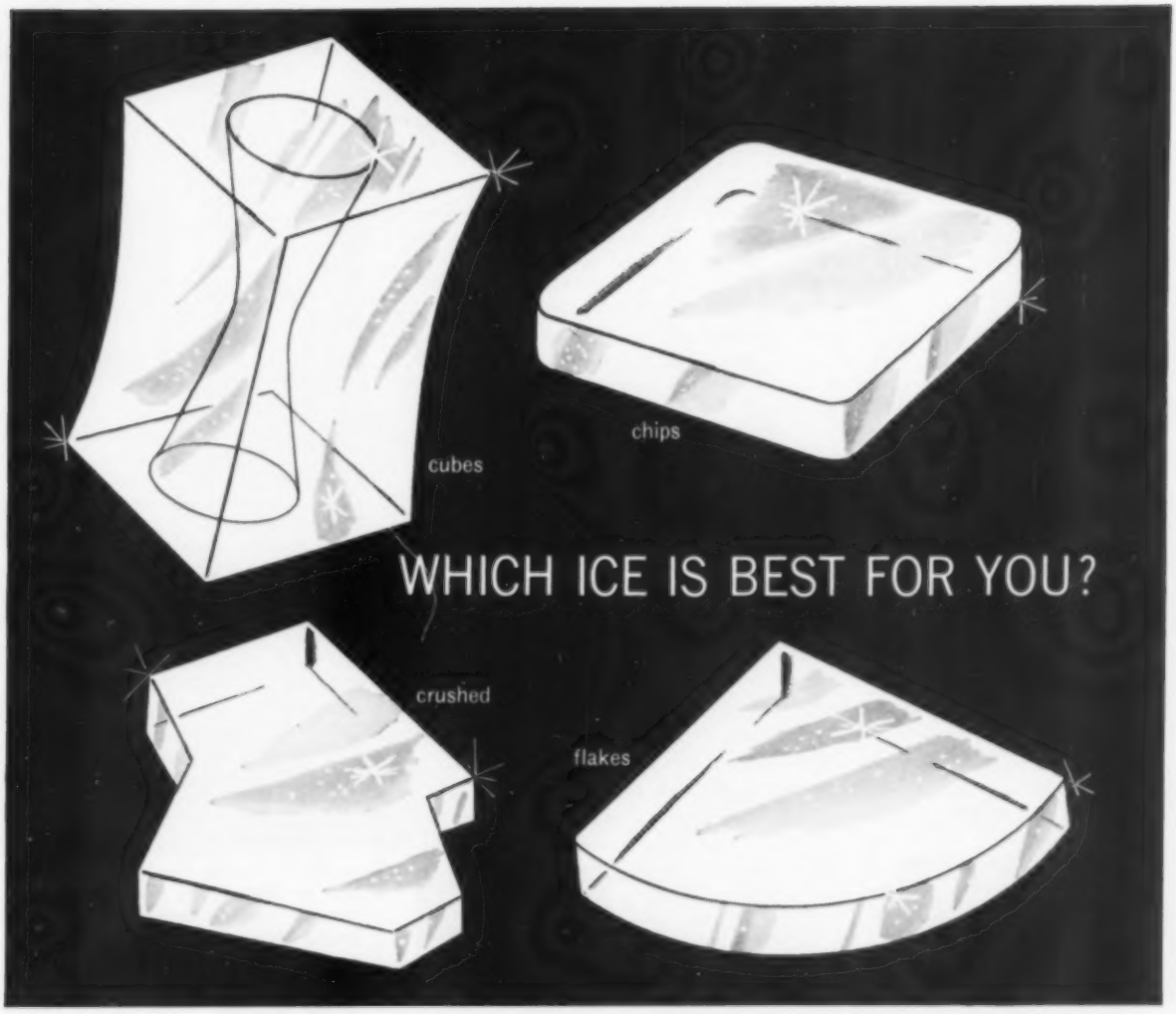
Frederick W. LaCava has been named administrative director of Ormond Beach Hospital, Ormond Beach, Fla., succeeding **Col. Henry C. Floyd.** Mr. LaCava formerly was administrator of Osceola Hospital, Kissimmee, Fla., and administrator and director of laboratories of General Hospital of Greater Miami, Fla.

Dr. Cecil G. Sheps

Dr. Cecil G. Sheps, general director of Beth Israel Hospital, Boston, has been named clinical professor of preventive medicine of the faculty of medicine, Harvard University. He is a member of the National Advisory Committee on Chronic Illness and Health of the Aged, Public Health Service, special consultant and member of the Hospital Facilities Research Section, and a board member of the American Nurses' Foundation.

Department Heads

Brian Adlington has been appointed administrative assistant in charge of purchasing at Cedars of Lebanon Hospital, Los Angeles. Mr. Adlington formerly was assistant administrator and purchasing agent at St. Luke's Hospital, Spokane, Wash., for eight years. It was also announced that **Mary Scales** has been appointed co-



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ordinator of volunteers at the hospital. Mrs. Scales served as director of recreation at the Veterans Administration hospital, Long Beach, Calif., for 12 years.

Mary A. Hnat has been named director of nursing service at St. Thomas Hospital, Aurora, Ill., succeeding **Sister M. Esther,** who has become director of the school of nursing. Miss Hnat formerly was evening supervisor at St. Vincent Charity Hospital, Cleveland.

Mary Hamilton has been appointed chief dietitian of City of Hope Medical Center, Duarte, Calif. Previously, she worked at City Hospital, Cleveland, and organized the dietary department of Highland View Hospital, Cleveland. She received a bachelor's degree in dietetics at Ohio University, and did graduate work at the University of Colorado.

Virginia Krause, assistant director of the medical record department at Wesley Memorial Hospital, Chicago, has been named director of the medical record department at Weiss Memorial Hospital, Chicago.

Thomas W. Surratt has been appointed manager of the business offices and controller of Rowan Memorial Hospital, Salisbury, N.C. He will be responsible for the over-all statistical and financial activities of the hospital. Mr. Surratt formerly was assistant administrator of Moore Memorial Hospital, Pinehurst, N.C.

Miscellaneous

Oscar W. Rexford

Oscar W. Rexford, vice president and operating manager of St. Louis Public Service Company, has been appointed head of Group Hospital Service, Inc., which operates the St. Louis Blue Cross Plan. Mr. Rexford succeeds **Elmer F. Nester,** executive director of the plan, who is retiring because of ill health. Mr. Nester joined the staff of Blue Cross in 1936 and became director in 1946. Mr. Rexford, a graduate of Washington University, is a member of the board of directors of many St. Louis organizations, including Bethesda General Hospital.

Helen M. Cullen, R.N., executive secretary of the Connecticut State Nurses' Association, has resigned. She will be succeeded by **Eleanor Lundblad, R.N.,** former assistant executive secretary and editor of the organization's monthly bulletin.

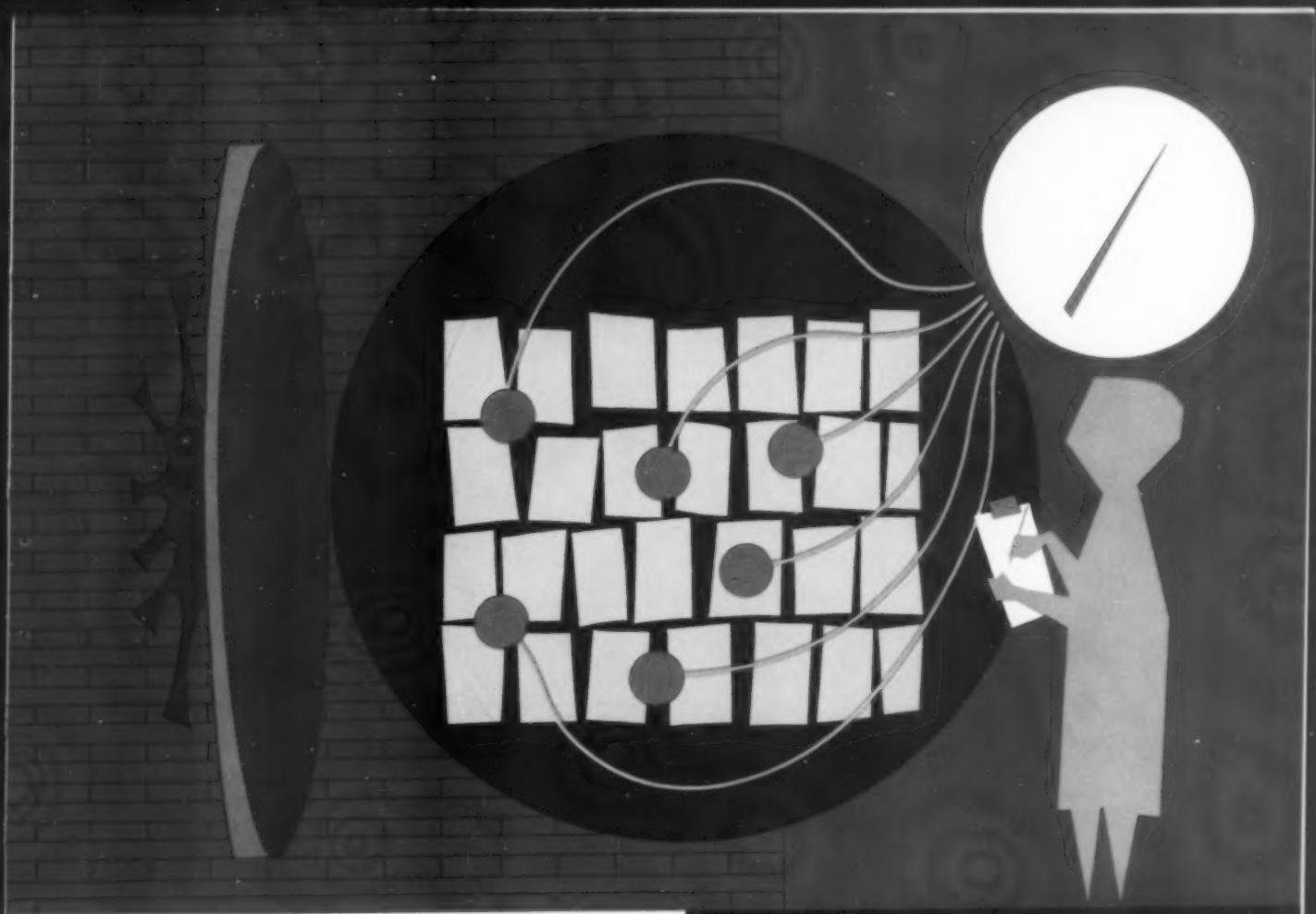
Dr. Harry N. Comando has been appointed to the newly created position of director of professional relations for Medical-Surgical Plan of New Jersey (Blue Shield). He has retired from active practice and from the board of trustees of Blue Shield to accept the post.

John H. Hunt, executive secretary of the American Society of Anesthesiologists since 1947, has announced his resignation. Mr. Hunt will continue to serve as consultant to the society until October 1958. **John W. Andes** was appointed to succeed Mr. Hunt, and **Paul E. Price** was named assistant executive secretary.

Deaths

Dr. Franklin Bliss Snyder, president of Northwestern University from 1939 to 1949, died last month of a heart attack at the age of 73. Following his retirement from Northwestern, he served as president of the board of managers of Presbyterian Hospital, Chicago, a post he held until 1956. He served on the board of Evanston Hospital Association, Evanston, Ill., from 1941 to 1955.

H. E. Henderson, 64, executive secretary of the Washington State Pharmaceutical Association for 20 years, died recently in Seattle. He was serving this year as president of the National Retail Druggists Association.



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POSITIONS WANTED

ADMINISTRATOR or ASSISTANT—Retiring from U. S. Navy Medical Service Corps; 15 years experience in administrative capacity in Navy Medical Department; experience in standardization and procurement of hospital equipment in the New York City Department of Hospitals; New England area preferred. Apply MW 19, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ADMINISTRATOR or SUPERINTENDENT—College graduate in hospital administration, public relations, personnel management; several years thorough practical experience; United States or Foreign. Apply MW 28, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ASSISTANT ADMINISTRATOR—R.N.; B.S. Nursing Education, M.S. Nursing Service Administration; good hospital background; prefer New York State or Pennsylvania. Apply MW 27, The Modern Hospital, 919 N. Michigan Ave., Chicago 11, Ill.

ANESTHESIOLOGIST—Board Certified; 12 years experience; last 5 years chief of approved department in large general hospital; prefer organize or head department; teaching experience; best recommendations. Reply MW 22, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

BUILDING OR MAINTENANCE ENGINEER — Twenty-five years experience; ten years supervisory experience dealing with construction and maintenance contractors, tradesmen, preventive maintenance programs; heavy experience in electrical, heating, and ventilation equipment; have complete working knowledge of the various trades; member of the American Institute of Electrical Engineers and National Association of Power Engineers; willing to assume complete responsibility for new start-up or existing operation; present location New York State; age 51; would relocate. Apply MW 16, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ENGINEER—Plant-Chief or maintenance superintendent; university graduate in mechanical and electrical engineering; licensed professional engineer and trades licenses in steam engineering, refrigeration, air conditioning, electrician, general building contractors, plumbing; thorough practical hospital experience. Apply MW 29, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

PURCHASING AGENT—Man; 11 years surgical supply business; 5 years hotel auditor; seeking change; Boston and vicinity; 250-beds up. Apply MW 20, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

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ADMINISTRATOR—Medical; three years on faculty medical school (full time teaching); two years, assistant director, 500-bed general hospital; five years, director, 700-bed hospital; FACHA.

ADMINISTRATOR—MHA; administrative residency, teaching hospital; 6 years, associate administrator, 500-bed university affiliated hospital; Member, ACHA.

ANESTHESIOLOGIST—Diplomate, American Board; 9 years, department anesthesiology, well known clinic, on staff medical school.

COMPTROLLER—B.S.; accounting manager (five years), comptroller (two years), 500-bed hospital; two years, director department, 1000-bed hospital.

FOOD SERVICE—Director hotel and restaurant services, 12 years; director department, 400-bed hospital, 3 years.

PATHOLOGIST—Diplomate; 4 years, associate pathologist, teaching hospital and on faculty of medical school as associate professor; 5 years, director department, 300-bed general hospital.

RADIOLOGIST—Diplomate (Diagnosis, Therapy); since 1952, associate radiologist, 300-bed hospital, in charge of resident training.

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ADMINISTRATOR—Some graduate work, accounting & business law; administrative assistant very large university hospital, 4 years; assistant administrator & then administrator, 155-bed hospital, 2½ years; administrator, 480-bed hospital, 5½ yrs.; seeks administration, 150-400 bed hospital, midwest, west-coast, or south; Member ACHA.

ANESTHESIOLOGIST—12 years, anesthesiology, highly regarded group, staffed by 80 men, mostly Certified and on teaching faculties; seeks directorship, department, anesthesiology, in larger hospital; on fee basis; Diplomate; early 40's.

EXECUTIVE HOUSEKEEPER — Male; late 40's; business school education; 10 years as executive housekeeper, very large general hospital system; seeks similar appointment; Southern states.

(Continued on page 162)

WOODWARD—Continued

EXECUTIVE HOUSEKEEPER—Early 40's; available July-August for challenging opportunity; experience qualifies to assist in expansion, open new hospital, establish training school for housekeeping personnel; seeks large hospital appointment at salary commensurate outstanding record; any area.

PATHOLOGIST—Five years, director of pathology, 250-bed, general hospital; Diplomate, CP, PA; prefers north-south Atlantic States.

MARRIED DOCTOR TEAM—Licensed in and seeking hospital position, Washington State; wife, 36, radiologist, Diplomate, both branches; husband, 36, Board qualified, Ob-gyn; 6 years, training, Ob-gyn, surgery, psychiatry; 2 years, Ob-gyn, USAF hospital; will teach part-time.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
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Cleveland, Ohio

BUSINESS MANAGER—Age: 36 years; B. A. Degree, Business Administration; 8 years administrator, 50 bed mid-western hospital; desires larger hospital.

ADMINISTRATOR — M.S. Degree, Hospital Administration, 1954; 4 years administrator, 75-bed Pennsylvania hospital; east or mid-west.

ADMINISTRATOR—M.H.A. Degree; 12 years experience; prefers southeast; excellent references.

PERSONNEL DIRECTOR—M.A. Degree, 1946; diversified experience as employee relations supervisor; past two years, 300-bed Michigan hospital.

COMPTROLLER—Or assistant administrator; 12 years auditor, 4 years chief accountant, 500-bed hospital.

DIRECTOR, NURSING SERVICE—M.A. Degree; 6 years assistant directress, large western hospital; director of nursing service, past 4 years, 300-bed Illinois hospital.

EXECUTIVE HOUSEKEEPER—2 years training Veterans Administration hospital, northwest; 2 years, 250-bed mid-western hospital.

POSITIONS OPEN

ANESTHETIST—Opening created by expansion of hospital. For information write Administrator, Baptist Hospital, Pensacola, Florida.

ANESTHETIST—Nurse; New 50-bed hospital; excellent working conditions and personnel policies. Contact Administrator, Dearborn County Hospital, P. O. Box 72, Lawrenceburg, Indiana.

ANESTHETIST—Nurse; R.N.A. for 215-bed hospital; excellent surroundings and personnel policies; $6300.00 starting salary with time and merit increments. Reply J. A. Anderson, Superintendent, Lutheran Hospital, Fort Dodge, Iowa.

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POSITIONS OPEN

ANESTHETIST—Registered nurse; salary from $425.00; commensurate with background and experience; accredited 44-bed general hospital in friendly community 7,000. Write Esther M. Squire, Administrator, Murphy Memorial Hospital, Red Oak, Iowa.

ANESTHETIST—Nurse; opening in obstetric department; 11:00 p.m. to 7:30 a.m: liberal employee benefit program includes vacation, sick pay, and holidays. Write Personnel Department, St. Joseph Mercy Hospital, 900 Woodward Avenue, Pontiac, Michigan.

ANESTHETIST—Nurse; excellent working conditions, beginning salary $400.00 with extra pay for call duty; four weeks' vacation annually; department under direction of M.D. anesthesiologist. Apply Personnel Dept., Mt. Sinai Hospital, Minneapolis 4, Minn.

RELIEF ANESTHETIST—For 4 to 6 weeks beginning July 15 or later; 60-bed general hospital; call time shared with another anesthetist; $450 a month with full maintenance, or $500 a month without. Call or write Donald Showman, Kennedy Deaconess Hospital, Havre, Montana. Phone 113.

ANESTHETIST—Nurse; for 215-bed general hospital; starting salary $450 a month with vacation, sick leave and retirement benefits. Apply Murray A. Hintz, Administrator, Bernalillo County-Indian Hospital, Albuquerque, New Mexico.

ANESTHETISTS—Wanted several nurse anesthetists for enlarged anesthesia department in a 250-bed general hospital located in a resort town eight miles from famous Wrightsville Beach, North Carolina. Write James Walker Memorial Hospital, Wilmington, North Carolina.

ANESTHETIST — Registered nurse; wanted. Write or call Dr. L. G. Merrill, St. Benedict's Hospital, Ogden, Utah, for details.

ANESTHETIST—Nurse; $400-$600 per month; excellent medical staff; 200-bed hospital; fringe benefits, health, life, retirement insurance; paid vacation-sick leave; hospital cafeteria, nurses' home accommodations. Contact E. J. Berg, Business Manager, Gundersen Clinic, La Crosse, Wisconsin.

DENTAL HYGIENIST—Must have completed a course in dental hygiene at a recognized school, college, or university; salary range $3360-$3960, liberal employee benefits. Apply Personnel Director Ancora State Hospital, Hammonton, New Jersey.

DIETITIAN—For Southern California county hospital near desert, mountains, and seashore; $378-$460; college graduation, year's internship, and ADA membership required; paid vacation and sick leave, part-paid health insurance, other benefits. Apply County Personnel, 236—3rd Street, San Bernardino, California.

DIETITIAN—A.D.A. or equal; full charge of department in 45-bed hospital; 75 miles east of St. Louis, Missouri; salary open. Apply Administrator, Salem Memorial Hospital, Salem, Illinois.

DIETITIAN—Opening in 400-bed hospital which is adding 120-bed rehabilitation unit; excellent opportunity in therapeutic or administrative work for A.D.A. registered person; salary commensurate with training and experience; liberal benefits. Apply Personnel Director, Iowa Methodist Hospital and Raymond Blank Memorial Hospital for Children, Des Moines, Iowa.

DIETITIAN—Teaching and therapeutic; must be A.D.A. member; new department and equipment; hospital is expanding to 250-beds; excellent personnel policies including 3 weeks vacation; salary in accordance with experience. Apply Personnel Director, Bethany Hospital, 51 North 12 Street, Kansas City, Kansas.

DIETITIAN—Graduate; administrative experience helpful; excellent pay, quarters, vacation and retirement plan. Write Sunshine Hospital, Grand Rapids 3, Mich.

DIETITIANS—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—A.D.A. or equal, full charge of department in 55-bed general hospital; modern kitchen, excellent conditions, salary open. Apply Administrator, Lakeview Memorial Hospital, Bath, New York.

STAFF DIETITIANS—One teaching; one therapeutic; A.D.A. members, hospital recently expanded to 450-beds, located in residential district; approved by J.C.H.A.; dietary facilities entirely new and air conditioned; dietetic program integrated with N.L.N. approved school of nursing, affiliated with Medical Research Institute 40 hour week, broad personnel policies and benefits; salary open. Apply Miss Rosemary E. Brown, Director of Dietetics, The Toledo Hospital, Toledo 6, Ohio, or call Greenwood 2-1121.

DIETITIAN—Assistant; excellent opportunity to gain administrative and therapeutic experience in 170-bed general hospital; JCAH approved; 40 hour week; salary open. Apply Administrator, Yakima Valley Memorial Hospital, Yakima, Washington.

DIETITIAN—Must be A.D.A.; 300-bed hospital enlarging to 500-bed hospital with completely new centralized service dietary department; duties generally therapeutic diet planning, patient contact, and instructing student nurses; salary open, well above average. Apply to Food Manager, Ohio Valley General Hospital, Wheeling, West Virginia.

DIETITIANS—ADA registered; positions in a system of 10 new general hospitals with large out-patient department; educational material and visual aids being developed for the instruction of patients and families; modern dietary department, centralized trayveyor; employee and visitor cafeteria; we are still developing nutrition and dietary instructions; hospitals in West Virginia and Kentucky; salary ranges begin at $4860 and $5340 per annum, depending on your qualifications; annual increments; 40 hour week, 7 paid holidays, 4 weeks paid vacation; employee health program; social security plus retirement plan. Write Miners Memorial Hospital Association. Box #61, Williamson, West Virginia.

DIRECTOR OF NURSING SERVICE—Expanding 300-bed West Coast hospital, metropolitan location; salary open; desire candidate with 2 years demonstrated progressive administrative experience plus MA in Nursing Administration, or 6 years comparable experience. Write MO 218, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR, SCHOOL OF NURSING — For accredited diploma school of nursing with student body of 170; Masters degree required; Baptist preferred; must be Protestant; 40 hour working week; salary commensurate with qualifications; excellent personnel policies, social security, group hospitalization. Apply MO 224, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF NURSES—To assume complete responsibility for organizing nursing service in new 50-bed hospital; B.S. degree desired but will consider persons with supervisory or administrative experience without degree. Apply Administrator, Dearborn County Hospital, P. O. Box 72, Lawrenceburg, Indiana.

ASSOCIATE DIRECTOR, NURSING EDUCATION—200 student university affiliated school using clinical facilities of 400-bed JCAH fully approved hospital which includes 115-bed pediatric unit; desire person capable of developing judgment, nursing skills and problem-meeting ability of a select group of girls recruited once each year; experienced masters nursing education degree candidate preferred, will accept B.S. degree candidate with demonstrated successful experience; salary open, 40 hour work week, 4 weeks vacation, sick leave benefits; position available August 1. Apply to Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

ASSISTANT DIRECTOR, SCHOOL OF NURSING—Assist with the administration of NLN fully accredited diploma program with university affiliation for basic sciences; 160 students; academic preparation and successful experience required; position offers opportunity for leadership and initiative; excellent personnel policies and pleasant working conditions; comfortable furnished apartment available if desired; ideal summer climate. Write Director, School of Nursing, St. Luke's Hospital, Duluth, Minnesota.

INSTRUCTOR—Clinical; needed for obstetrical nursing; position open July; integrated program; affiliated with Drake University; 200 students in school; 400-bed, fully approved, non-profit hospital; minimum qualifications: B.S. degree, preferably in Nursing Education; salary open; 40-hour work week; 20 working days vacation; sick benefits. Apply Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

INSTRUCTOR—Psychiatric nursing; progressive State Hospital with affiliate nursing program; starting salary dependent upon academic qualifications, experience and personal qualifications; starting range from $4140 to $8100 plus self-maintenance, liberal sick time, holidays, paid vacation. Write Dr. J. O. Cromwell, Superintendent, Mental Health Institute, Independence, Iowa.

NURSING-CLINICAL INSTRUCTOR—Medical and surgical; degree or working toward degree; suburban 220-bed fully accredited hospital; short distance from New York City; full maintenance available, attractive living quarters; good salary, regular increments, 4 weeks vacation; pension plan and social security. Apply Director of Nursing, Somerset Hospital, Somerville, New Jersey.

INSTRUCTORS—Clinical; medicine and surgery, and obstetrics; to increase faculty; excellent personnel policies with educational advantages; 40 hour week, salary open; new hospital and school facilities; 35 miles from central Philadelphia; prerequisite: B.S. degree in nursing education; position open. Apply Director of Nursing, Pottstown (Pa.) Hospital.

MISCELLANEOUS INSTRUCTORS—Medical—Surgical—Obstetrical—Operating Room; should have a B.S. degree in Nursing Education and a minimum of two years experience in two of the following positions: Instructor, Assistant Instructor, Head Nurse; 366-bed private general hospital with expansion program to be completed soon; 150 student School of Nursing with three year diploma course. Contact Personnel Department, Milwaukee Hospital, 2200 West Kilbourn Avenue, Milwaukee 3, Wisconsin.

(Continued on page 164)

THE TIME: *Now*

THE PLACE: *Auburn, New York*

THE HOSPITAL: *Auburn Memorial, one of two in the community.*

THE NEED: *$950,000, to supplement a $300,000 Federal grant, for a 60-bed chronic unit, a psychiatric section, expansion of physical and occupational therapy departments.*

THE COUNSEL: *Will, Folsom and Smith, counsel to both hospitals in previous campaigns, retained for a program of interpretation and fund raising, geared to the nature of the project and the character of the community.*

THE RESULT: *Success—a total of $1,105,155, in addition to $300,000 in Federal funds.*

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POSITIONS OPEN

CONSULTING MEDICAL RECORD LIBRARIAN AND MEDICAL RECORD TECHNICIAN—New 40-bed hospital and neighboring hospital wish to engage qualified medical record librarian; salary open; location northwest Wisconsin; 40 hour work week; organizational ability required. Apply Mo 230, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ASSISTANT MEDICAL RECORD LIBRARIAN—University town, 170-bed hospital, approved; standard nomenclature; salary open, commensurate with training and experience. Apply Charles Becker, Jr., Administrator, Burnham City Hospital, Champaign, Illinois.

LIBRARIAN—Registered or equal; full charge of department in 45-bed hospital; 75 miles east of St. Louis, Missouri; salary open. Apply Administrator, Salem Memorial Hospital, Salem, Illinois.

LIBRARIAN—Medical record; registered to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

LIBRARIAN—Medical Record; as assistant in 240-bed hospital; excellent working conditions and personnel policies. Apply Personnel Manager, Peterborough Civic Hospital, Peterborough, Ontario.

NURSING MISCELLANEOUS — Portland, Oregon, is a fine place to live; The University of Oregon Medical School Hospital is a fine place to work; Staff positions open in Medical, Surgical, Pediatric, O.R. and Isolation units; beginning salary $310.00 per month with six months' experience; liberal personnel policies; opportunities for taking courses leading to baccalaureate or masters degrees at nursing school on campus; reduced tuition rates for employees. Write for information to Director of Nursing, University of Oregon Medical School Hospital, Portland 1, Oregon.

NURSING MISCELLANEOUS—Head nurses and Registered General Duty Nurses for surgical, medical and obstetrical departments; gross salary for nurses currently registered in Ontario, $235.00 per month, extra allowance made for head nurses; good personnel policies; new facilities; comfortable nurses residence; 8 hour rotating shifts, 44 hour week; 1 day off 1 week, 2 the next; 1½ day holiday allowed per month, same sick time accumulated to 90 days; 8 legal holidays per year; the equivalent of single train fare paid up to $40 after 1 year of service. Apply Superintendent, Lady Minto Hospital, Cochrane, Ontario.

NURSES—Operating room and staff; for 227-bed pediatric hospital in sunny California; salary $315 per month with differential for operating room and evening and night duty; 5 day, 40 hour week; liberal personnel policies including vacation, sick time and retirement. Apply Director of Nursing, Childrens Hospital Society, 4614 Sunset Blvd., Los Angeles 27, California.

NURSE—Operating room; for modern air-conditioned, two room suite, in 52-bed general hospital; 12 days sick leave, 2 weeks vacation annually, paid holidays, annual bonus, 40-hour week; salary open. Apply Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSES—Registered; for modern psychiatric hospital in Greens Farms, Connecticut; 1 hour from New York; Hall-Brooke nurses have 8-hour duty, optional 5 or 6 days week, nicely furnished private rooms; excellent salary, 7 paid holidays annually, or equivalent; sick leave; vacation, minimum 2 weeks, maximum 4 weeks dependent on length of service; profit-sharing plan; psychiatric experience not necessary; registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Directress of Nursing, Hall-Brooke, Box 31, Greens Farms, Connecticut. Tel. Westport—Capital 7-5105.

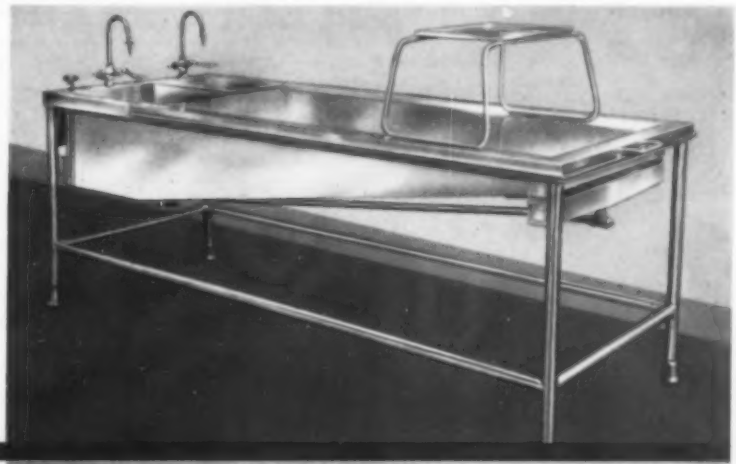
NURSES — Registered; immediate openings; starting salary $280 month with opportunity for advancement; room, board and laundry; annual vacation, liberal sick leave, 40 hour week. Apply Personnel Office, Mental Health Institute, Independence, Iowa.

(Continued on page 166)

✓ CONVENIENCE
✓ SURE SANITATION
✓ DURABILITY... BLICKMAN builds these in with every autopsy table

When equipment must provide fast and complete sanitation, convenient use, plus *long-term* dependability—examine the details of construction. Into every autopsy table, Blickman builds these famous construction features: high-polish, heavy-gauge stainless steel... crevice-free surfaces... literally invisible welds... fully *rounded* corners and coves ...carefully planned, correctly pitched drainage.

These are some of the reasons why Blickman autopsy tables save clean-up time and labor, while protecting personnel. In terms of service life, too, this top-quality construction makes Blickman-built autopsy tables a paying investment.



This **BRUNSWICK MODEL** is the one in most general use throughout the country. Anti-contamination feature prevents back-syphonage. All fluids flow directly into a film of constantly running water, thence to waste outlet. Instrument tray slides along perforated removable top. Choice-section sink, with hot and cold water supply, at foot end.

HARTFORD MODEL—Trough slopes from both ends. Trough, foot-end sink, and drainboard form completely welded assembly. Removable cross-bars rest on ledges which are perforated so that entire trough may be flushed thoroughly. Removable stainless steel tray is mounted on adjustable standard.

Send for bulletin No. 5 ATC which describes, with complete specifications, these and eight other models of Blickman stainless steel autopsy tables.

SEE US AT: Catholic Hospital Assoc., Atlantic City, N.J., Booths #541, 543, June 23-26, 1958

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Look For This Symbol of Quality Blickman-Built

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classified advertising

POSITIONS OPEN

NURSES—Registered; openings due to retirement; 600-bed Tuberculosis Hospital located forty miles south of Jackson; beginning salary $200 month with full maintenance; merit increases; personnel policies also include retirement pension plan, social security, 15 days vacation, 15 days sick leave, and 6 annual holidays. Write Director of Nursing, Mississippi State Sanatorium, Sanatorium, Mississippi.

NURSES—Registered; female, with New York State licenses. Apply to Mr. John C. Doyle, Assistant Administrator, 9 East 91st Street Hospital, New York 28, New York.

NURSES—Registered; 170-bed general hospital, located in "The Fruitbowl of the Nation." ideal climate, convenient recreational facilities year round; starting base salary $360.00 per month. Apply Director of Nurses, Yakima Valley Memorial Hospital, Yakima, Washington.

NURSES—Staff; staff positions in all clinical areas including psychiatry, poliomyelitis and respiratory center in new, 800-bed air conditioned hospital; 40-hour week; 3 weeks vacation annually; beginning salary; staff nurses, $275 monthly; periodic increments; opportunity for college study through bachelor's degree program. Write Director of Nursing Service, Eugene Talmadge Memorial Hospital, Medical College of Georgia, Augusta, Georgia.

PHYSICAL THERAPIST—Male or female; excellent opportunity to head up new department in recently expanded 150-bed general hospital; retirement plan, social security, liberal fringe benefits; salary open. Write Administrator, Alpena General Hospital, Alpena, Michigan.

SUPERVISOR-INSTRUCTOR—Operating room; 209-bed general hospital; NLN fully accrediated school of nursing; 96 students; 40 hour week; special clinical preparation in operating room supervision; salary open, liberal personnel policies. Apply Director of Nursing, Middlesex Memorial Hospital, Middletown, Connecticut.

SUPERVISORY—Medical-Surgical; a capable nurse supervisor for 239-bed medical-surgical unit of 400-bed hospital having 200 student School of Nursing; prefer person with degree in Nursing Service Administration, but will consider others; 5 day, 40 hour work week; liberal vacation and other benefits. Apply Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

SUPERVISOR—Clinical instructor; for 22-bed, open ward, new psychiatric unit; NLN accredited; degree or post course, teaching experience desired; salary open. Apply Nurse Administrator, Northwest Texas Hospital, Amarillo, Texas.

SUPERVISOR—Pediatric teaching; 37-bed pediatric ward, 250-bed hospital, full NLN accreditation, JACH; degree and experience preferred; liberal personnel policies; salary open. Apply Nurse Administrator, Northwest Texas Hospital, Amarillo, Texas.

TECHNOLOGIST—Laboratory; 250-bed hospital salary open. Apply MO 171, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

TECHNICIAN—Laboratory; for 41-bed, modern hospital, located between Phoenix and Tucson, Arizona; salary $400-$450; 40 hour week; overtime pay; 25% of all monthly call work; 2 to 3 weeks vacation with pay; 12 days a year sick leave, accumulative to 36 days; 7 paid holidays a year; social security; group hospital insurance available. Reply to Hoemako Hospital, Box 1837, Casa Grande, Arizona.

TECHNICIAN—Laboratory; 236-bed general hospital 30 miles from New York City; interesting position with advancement in progressive hospital. Contact Personnel Office, Morristown Memorial Hospital, Morristown, New Jersey.

TECHNOLOGISTS—Medical registered 160-bed general hospital, college town, 20 miles west of Milwaukee, major expansion program including new department of laboratory medicine started in spring of 1957; affiliation with Carroll College for training of medical technologists now in development stage; full time pathologist. Apply Personnel Department, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

(Continued on page 168)

Are the floor maintenance costs in your hospital running too high? Do your floors get dirty too quickly? Are they hard to get clean? Do they require constant, time and budget consuming attention?

Solution:

Vina-Lux® FLOORS WITH Micromatic Veining

Vina-Lux can solve your problem. Its tight, smooth surface won't absorb dirt—its vinyl composition resists greases, acids. Vina-Lux saves both labor and material in floor maintenance. Write for folder.

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POSITIONS OPEN

TECHNICIAN—Famous dude ranch area needs laboratory technician immediately. Apply St. John's Hospital, Jackson, Wyoming.

Telephone: RAndolph 6-5682

ADMINISTRATORS—(a) Small, short-term hospital building program in process; one with good experience, about $7,000—higher when new addition is built; mideast. (b) 250-bed fully approved, voluntary general hospital; about $18,000; degree not necessary but must have demonstrated record of experience; east. (c) JCAH hospital expanding to 400-beds; requires Member of Fellow ACHA; Florida coast town; extremely attractive area. (d) 130-bed, JCAH hospital; salary commensurate with training and experience; small town serving area 40,000; midwest. (e) 80 bed, voluntary, general JCAH hospital; should have degree; $6,000; vicinity St. Louis. (f) Voluntary, general JCAH hospital now expanding 75-beds; requires degree; Ohio. (g) General hospital, 90-beds, newly opened; Southern California. (h) 120-bed hospital, established 1913; may add new wing; one with good experience; $7,000; midwest. (i) Director of medical education; also conduct clinical research; 450-bed fully approved hospital; $13,000, excellent retirement plan; New England.

ASSISTANT ADMINISTRATORS—(j) Assistant director; requires Hospital Administration degree and 1 year's experience; 230-bed fully approved hospital; university city 200,000; West Mountain State. (k) To direct fairly large TBc unit of 1000-bed hospital association; opportunity for advancement; southern California. (l) Requires graduate Hospital Administration course; responsible several departments; 300-bed, JCAH hospital; salary open, depending upon qualifications and experience; town 50,000 serving larger area; east. (m) Assistant; voluntary, general 225-beds, teaching program; about $8,000; large city on Lake Michigan.

ADMINISTRATIVE POSTS—(n) Accountant; 6 years experience, strong on costs, systems, procedures; able direct staff of 30; $6,000-$7,000; large fully approved teaching hospital; midwest. (o) Comptroller; duties: set up simple routine accounting, credits and collections and inventory control; 12 hospitals; some travel; to $11,000; excellent potential; midwest. (p) Personnel director; voluntary general JCAH hospital, 300-beds; $5,000-$6,000; town 60,000; central.

EXECUTIVE HOUSEKEEPERS — (a) Excellent opportunity for imaginative housekeeper to replace individual retiring after 20-year tenure; must have organizational ability; general hospital now expanding to over 500 beds; excellent eastern location. (b) Full charge staff of 50; voluntary general hospital 400-beds; California coastal city. (c) Also responsible nurses home, house officers' quarters; fully approved 375-bed general hospital; large New England city. (d) 600-bed Tuberculosis institution, approved JCAH; Carolina college community. (e) General hospital 300-beds; ideal location, large city, Pacific Northwest.

(Continued on page 170)

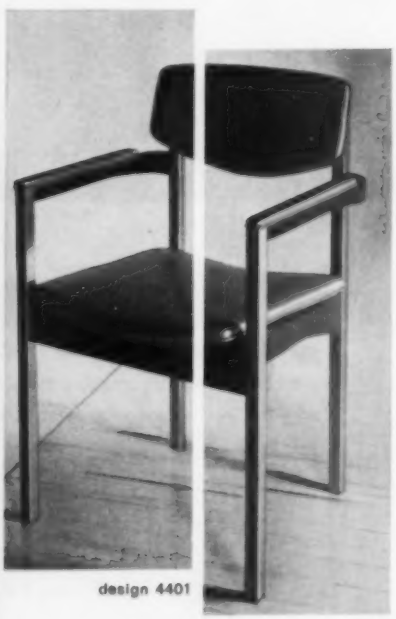
The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 NORTH MICHIGAN AVENUE, CHICAGO

ADMINISTRATORS—(a) Commissioner of hospitals to direct two hospitals, combined capacity, 800-beds; medical degree or degree in hospital, business or public administration and extensive experience required; university city, midwest. (b) Administrator, clinic com-



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DIAL-IN System

* Dial IN for Doctors

A New Way to Find Out Which Doctors are In...

Auth DIAL-IN Doctors' In and Out Systems

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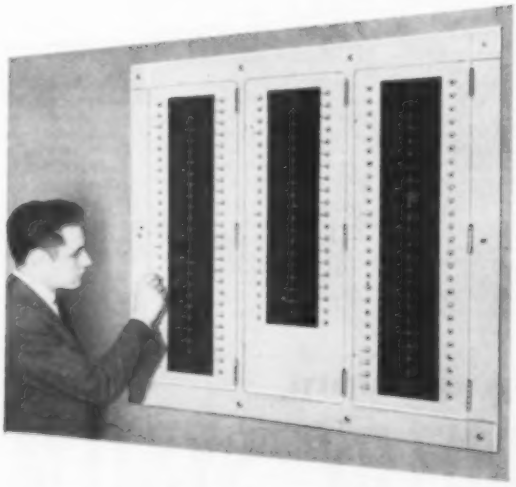
- *Facilitate the Operator's Work*
- *Reduce Installation Cost*
- *Add Flexibility to the System*



Doctors register IN *and* OUT *on conventional entrance registers...*

BUT...*the telephone operator only needs the small* IN-FORMER *to tell her who is in.*

Auth's DIAL-IN Doctors' In and Out System is built around a new device...the IN-FORMER...a small unit, no larger than a telephone, which replaces the conventional doctors' In and Out indicator and message-flash keyboard in the hospital telephone operator's room. The IN-FORMER reveals to the telephone operator which doctors are in. It solves the space problem in that room for the design architect and engineer, and saves considerable expense in installation time and material. The control rack for the device can be located anywhere convenient to the entrance register.

The IN-FORMER, when dialed by the operator, will disclose whether any doctor whose number she dialed has registered IN on the entrance register. If he has done so a white "IN" lamp will glow...if he has not an amber "OUT" lamp will glow. The IN-FORMER can also set up...and cancel, at will...a message-flash to attract any doctor's attention when he enters or leaves the hospital.

In hospitals with more than one telephone operator each operator uses an IN-FORMER...without interference. In fact, its small size and low cost make it practical for others, such as the supervising nurse or Administrator, to use one.

The advantages of Auth's DIAL-IN system, particularly for large hospitals with many staff and visiting doctors, are manifold. You can secure more information from the local Auth representative or by writing for "Auth DIAL-IN System."

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Auth Electric Co., Inc.

LONG ISLAND CITY 1, NEW YORK

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POSITIONS OPEN

MEDICAL BUREAU—*Continued*

prising 100 physicians; 1300 physician-patient visits, 1000 laboratory services, daily; outstanding opportunity; man of top calibre required; west. (c) Administrator; new 200-bed general hospital; near New York City; $12,000-$15,000. (d) General hospital built in '55; 75-beds; Florida. (e) Assistant; 300-bed general hospital; suburb, large city, Pennsylvania. (f) Nurse administrator; new 60-bed hospital; wealthy farming area, Iowa; $6600, maintenance. MH6-1

ANESTHETISTS—(a) Two; 300-bed general hospital; university city, Ohio; $7200. (b) Association, group of anesthesiologists; Pacific Northwest; $500. (c) Busy surgery; 300-bed hospital; Mexican border; $6000 up. MH6-2

DIETITIANS—(a) Qualified reorganize, direct dietary department, 100-bed hospital; suburb, large university town; $6600. (b) Serve as consultants, food service organization; east, midwest; $5200 up. MH6-3

DIRECTORS OF NURSING—(a) Director of Nursing School and Service; new modern 600-bed hospital; collegiate program and 3-year school; to $10,000; east. (b) Director of nursing service; 200-bed general hospital; most ideal Arizona vacation land; $6000. (c) Assistant director of nurses must have initiative; strong in service administration; capable of complete responsibility; important 450-bed hospital; outside U.S.; $7000 up. MH6-4

MEDICAL BUREAU—*Continued*

EXECUTIVE PERSONNEL—(a) Business manager; degree with major in accounting, considerable experience; would supervise 40 employees, responsible for all accounting functions; $6000-$7200; university city, midwest. (b) Comptroller; university hospital; 900-beds; $6500-$8500; west. (c) Personnel director; newly established position, 350-bed hospital; Pennsylvania. (d) Purchasing agent; degree, minimum 3 years experience; 350-bed hospital; university town, Michigan; $7000. (e) Public relations director; 300-bed general hospital; near Chicago. (f) Food service director; 500-bed teaching hospital; $10,000; south. (g) Executive housekeeper; 450-bed hospital; university city; east. MH6-5

FACULTY POSTS—(a) Educational director; 3-year program, 350-bed hospital; Master's preferred, not required; $6000-$7200; California. (b) Instructors in pediatrics and OB, $5000-$5500; 450-bed hospital; 140 students; beautiful city, outside U.S.; delightful climate. MH6-6

MEDICAL RECORD LIBRARIANS—(a) Chief, act as consultant, supervise departments, 4 hospitals; university city, middlewest; minimum $6000. (b) Assistant; 13 in department; new 400-bed hospital; Florida. MH6-7

SUPERVISORS—(a) Qualified supervise and teach operating room program, 500-bed hospital; 7000 operations annually; $5000-$6000; vicinity New York City; (b) Supervise and teach, nursing personnel, new 60-bed patient unit; clinic and hospital serving industrial group, south; $535. (c) Supervise EENT department; $425, maintenance; Chicago area. MH6-8

MEDICAL EMPLOYMENT SERVICE
59 East Madison Chicago 2, Ill.
ANdover 3-5663-64
Alfred E. Riley, R.N., MSHA Director

ADMINISTRATORS—(a) 200-bed new hospital; south; salary open. (b) 150-bed hospital; south; salary open. (c) 100-bed new hospital; southeast historical city; salary open. (d) 50-bed hospital; New Jersey; salary $8,500. (e) 50-bed hospital; Wisconsin; salary open. (f) 35-bed hospital; Wisconsin; salary $7,500.

ASSISTANT ADMINISTRATORS—(a) 50-bed hospital; Colorado; salary $500. (b) 250-bed hospital; Ohio; salary open. (c) 60-bed hospital; Virginia salary open. (d) 300-bed hospital north; salary open.

COMBINATION ADMINISTRATORS—(a) 30-bed new hospital; Utah; seeking administrator and anesthesia combination. (b) 40-bed hospital Texas; combined X-Ray and anesthesia duties. (c) 50-bed hospital; south; seeking a person skilled in anesthesia and administration; salary open; coast location; resort area.

BUSINESS MANAGERS—(a) 250-bed hospital; Illinois; salary $550 per month; accounting background necessary. (b) 200-bed hospital; Ohio; salary open. (c) 100-bed hospital; New England; salary open.

PERSONAL DIRECTOR—(a) 300-bed hospital; Ohio; salary open.

(Continued on page 172)

new **carrom** adjustable-height beds

AT NEW LOW PRICES

MANUAL ADJUSTABLE-HEIGHT

- Fingertip operation, even under heavy load
- Smooth-running, ball-bearing crank mechanism
- Single crank for easy height adjustment

ELECTRIC ADJUSTABLE-HEIGHT

- Raises, lowers, at touch of a switch
- Automatic stops at high and low positions
- Powerful, safe, heavy-duty, lubricated motor, fully protected against thermal overload
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Designed and engineered for superior performance at prices you can afford to pay! These two new Carrom beds can be set up as easily as conventional beds. Indestructible ball-bearing pulleys assure smooth operation, posts are accurately machined for easy and noiseless height-adjustment. Additional quality features include corner posts that accommodate an irrigator rod and fracture frame, and heavy-duty, Trendelenberg-type spring to insure patient comfort. Birch wood end panels add a beautiful, home-like appearance. Choice of colors on end panels. Write for full details today.

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POSITIONS OPEN

MEDICAL EMPLOYMENT — *Continued*

FOOD SERVICE MANAGERS—(a) Large food management company; has four vacancies for experienced managers; hospital work also industrial area; salary range $500 and up; ½ of commission fee paid; Illinois area, metropolitan city.

LABORATORY TECHNICIANS—(a) ASCP chief; male; large laboratory; metropolitan city, Illinois; salary $550 per month; administrative duties. (b) Bio-Chemist MS or Ph.D. level; Illinois; salary $600 and up. (c) Ohio, 200-bed hospital; $400 per month. (d) Chicago; ASCP registered; $400 and up.

DIRECTOR OF NURSES—(a) 300-bed; Missouri; MS Degree, registered; commission fee paid.

ANESTHETISTS—(a) Nurse anesthetist; 125-bed hospital; near Chicago; salary beginning $500 per month; 40 hour week. (c) 100-bed hospital; Wisconsin; $600 per month; male or female. (d) other areas in hospitals; male or female $500 to $750 per month.

X-RAY TECHNICIANS—(a) Chicago hospital; salary $300 to $325. (b) Southern Illinois; 100-bed hospital; $275 to $325 depending upon experience.

MEDICAL EMPLOYMENT — *Continued*

HOUSEKEEPERS—(a) Male; 200-bed Chicago hospital; salary open. (b) 400-bed hospital; Chicago; male; assistant position open; salary open. (c) 200-bed hospital east; salary open; female preferred. (d) 100-bed hospital west; salary open.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ASSISTANT ADMINISTRATOR—(a) M.H.A. Degree, preferred. 150-bed hospital, mid-west. (b) Administrative assistant; 300-bed Pennsylvania hospital. (c) 200-bed New York and New England hospitals.

ADMINISTRATOR—(a) 65-bed hospital, central state. (b) 40 bed hospital, Ohio. (c) 55-bed hospital, Pennsylvania; open September.

COMPTROLLER—(a) 400-bed hospital, Pennsylvania. (b) 200-bed hospital, Massachusetts. (c) 400-bed hospital, mid-west. (d) Accountant; 150-bed Ohio hospitals, Indiana, Pennsylvania.

DIRECTORS OF NURSING—(a) To $8,000; east, mid-west, westcoast. (b) Directors, nursing service; $6,000; 200-400 bed hospital, Ohio, New York, Indiana, California.

TECHNICIANS—(a) To $475. (b) X-ray; 200-400 bed hospitals, Ohio. (c) Physiotherapists; $400. (d) Medical record librarians; attractive situations.

(Continued on page 174)

INTERSTATE—*Continued*

EXECUTIVE HOUSEKEEPERS (a) 400-bed hospitals, Iowa, Kansas, Ohio, New Jersey. (b) 175-bed hospital, Pennsylvania, Massachusetts, Virginia, New York.

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

EXECUTIVE PERSONNEL—(a) Cost accountant; 225-bed hospital; middle west $7200. (b) Personnel director; middle west; 400-bed hospital—700 employes; man or woman. (c) Purchasing agent; east; 185-bed hospital. (d) Personnel director; east; 400-bed hospital; man or woman; prefer hospital experience (e) Business manager; middle west; 360-bed hospital; good accounting background $7200 minimum.

DIRECTORS OF NURSING—(a) California; 360-bed hospital—expanding; near San Francisco. (b) East; 200-bed hospital in city of 40,000; $8000. (c) Nursing Coordinator; University; prefer Masters or Ph.D. but will consider good experience in nursing administration; to $9500. (d) Assistant; middle west; 220-bed hospital; $6000. (e) Middle west; 220-bed hospital; 235 employes; $7500. (f) New England; 225-bed hospital near sea coast; to $7000. (g) Southwest; 50-bed hospital; expanding to 100-beds to be completed by end of year; wonderful resort area; $6000. (h) South; 150-bed hospital in lovely town near several large cities; $6500 plus two room apartment.

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hospital campaign
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Shaded area indicates two new floors added to hospital wing. Improvements will provide expanded maternity, nursery, surgical, pediatrics and emergency facilities and increase bed capacity by 25 percent.

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If your hospital is planning a fund-raising campaign this year or next, write to Ketchum, Inc. now. We will be happy to discuss your problem with you. There is no obligation for early counsel.

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(Continued on page 175)

PLACEMENT BUREAUS

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Suite 618—ANdover 3-5293
Dorothea Bowlby, Director

A Specialized Employment Service for Medical and Hospital Personnel. (Men and Women.) For Administrators, Personnel Directors, Business Managers, Dietitians, Physicians, Directors of Nurses, Therapists, Pharmacists, Medical Record Librarians, Anesthetists, Public Relations Directors, Housekeepers, Bacteriologists, Biochemists, Medical Technologists, X-Ray Technicians, Food Service Managers. All inquiries from applicants are kept strictly confidential.

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NURSING AND MEDICAL BOOKS
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SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA offers a four month course in operating room technic and management to registered graduates of accredited schools of nursing. Registration fee $20.00. Full maintenance and $30.00 monthly cash allowance given. Apply to Director of Nursing Service, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

SCHOOLS—SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

UNIVERSITY OF MICHIGAN School for Nurse Anesthetists offers a 16 month course for nurses interested in anesthesia. Accredited by the American Association of Nurse Anesthetists. The training includes all technique in inhalation, intravenous, and rectal anesthesia. Unlimited opportunities for endotracheal intubation and open chest anesthesia. Stipend provided. For information write, School for Nurse Anesthetists, University Hospital, Ann Arbor, Michigan.

SCHOOLS—SPECIAL INSTRUCTION

SAINT AGNES HOSPITAL, offers anesthesia course to graduate nurses. Stipend given. Write to St. Agnes Hospital, School of Anesthesia, 1900 South Broad St., Philadelphia 45, Pennsylvania.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

New yellow tinted AEROPLAST® PROVIDES ADDED BENEFITS IN PATIENT CARE

In clinical use as a primary surgical dressing, as a secondary dressing after removal of initial gauze-tape, or as a skin protectant to prevent or clear excoriation—Aeroplast surgical dressing demonstrates* unique advantages:

CHOICE OF SIZES

12 oz. tinted
for frequent operating room use

3 oz. tinted
convenient for surgical carts and for office use

6 oz. clear
the original Aeroplast still available

Rx no longer needed

- **easy, rapid spray-on technic**
- **conforms to problem wound contours without tape or bulk**
- **plastic film forms waterproof bacterial barrier; antibacterial; dependably sterile dressings**
- **protects incision and adjacent area from drainage, urine, feces and other outside contamination**
- **permits visual inspection without removing dressing; allows free access for palpation and auscultation; no undesired restriction of respiration or circulation**
- **increases patient comfort; no bulk, no tape; non-sensitizing, non-allergenic**

16 MM COLOR-SOUND FILM now available for professional meetings . . . to schedule write: Aeroplast **CORPORATION**
420 Dellrose Avenue, Dayton 3, Ohio

*Reports of clinical use sent on request

®AEROPLAST—U.S. PAT. NO. 2,804,073

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 196. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Liquid-Oxygen Cylinder For Bedside Therapy

Designed originally to supply oxygen piping systems, the LC-3 liquid oxygen

cylinder converts liquid oxygen to a gas for use at the patient's bedside. It offers added convenience, safety and economy in administering oxygen by tent in hospitals without piping systems.

The LC-3 holds the equivalent of the contents of more than twelve standard oxygen cylinders, providing a supply for four to five days of therapy. With its use it is unnecessary to keep the usual three standard cylinders holding oxygen as a gas under high pressure at the bedside to supply the needs for 24-hour administration. The one cylinder also eliminates the switching from empty to full cylinders during the day and the daily removal of spent cylinders and replacement with fresh ones. Time is saved and a constant supply ensured with the LC-3. **Linde Co., Div. of Union Carbide Corp., 420 Lexington Ave., New York 17.**

For more details circle #664 on mailing card.

"Patient-Proof" Mattress Guards Against Infection

Sanitized ticking covers the Simmons "Patient-Proof" Mattress developed to help guard against the spread of infections. The

Sanitized mattress does not produce heat, yet it is waterproof, thus eliminating the need for rubber or plastic protective sheeting. It can be washed repeatedly without affecting the Sanitizing, and the mattress is sealed so that no moisture can get inside. The Sanitized ticking inhibits the growth of germs and bacteria, retards the growth and action of fungi, and is anti-static, non-toxic, non-irritating and resistant to mold and mildew. Sanitizing lengthens the life of the ticking without affecting its appearance, feel or color. Simmons Beautyrest for Hospitals, Hospital-Bilt and Dorm-Bilt mattresses are also obtainable with Sanitized ticking. **Simmons Company, Merchandise Mart, Chicago 54.**

For more details circle #665 on mailing card.

Erlenmeyer Flasks of Kimax Heat-Resistant Glass

Kimax, KG-33 borosilicate glass developed by the Kimble Glass Company, subsidiary of Owens-Illinois Glass Company, is used to form the new Screw-cap Erlenmeyer Flasks. Available in four sizes, the new flasks of heat-resistant glass are fitted with black plastic screw-caps containing a sealed-in rubber composition liner. They are especially useful for chemical and biological laboratory procedures

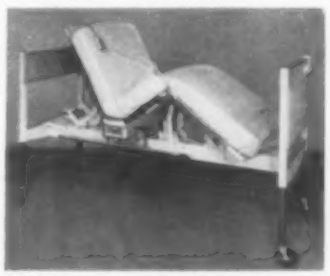
since they keep solutions and media both air and vapor-tight.

Use of the Screw-cap Erlenmeyer Flasks prevents drying out of media and cultures, and permits shaking of contents without spillage and controlled aeration by slight loosening of the cap. The heat-resistant, low expansion Kimax glass makes the new-type flasks stable, preventing contamination of critical contents. **Glasco Products Co., 111 N. Canal St., Chicago 6.**

For more details circle #666 on mailing card.

Fully Motorized Bed Has Revolutionary Frame

A new motorized hospital bed with push button patient control is introduced by American Metal Products Company, originators of electrically-powered seats. The bed has a number of innovations. The open design of the frame facilitates bed making and patient care as there are no side obstructions. The motor mechanism is completely contained in the center section where controls can be turned off, away from the patient's reach, when necessary. The special three-piece mattress panels replace the customary spring and eliminate the need for bed boards. They are easy to keep clean and sanitary. A footrest panel under the mattress is raised manually. Side rails store out of the way under each side



of the bed and are raised and lowered by one-hand operation.

The bed has eight distinct motorized actions but is simple to control. It is designed to withstand constant patient use and stops automatically at maximum action even if the patient should not release the push button. Motorized action carries the bed up to 36½-inch nursing care height, down to 21½-inch patient height, and raises and lowers the various mattress sections as desired. Every detail has been carefully engineered for efficient operation. **American Metal Products Co., 5959 Linsdale, Detroit 4, Mich.**

For more details circle #667 on mailing card.

Labor-OB Room Stretcher Has Wide Litter Top

A litter top 4½ inches wider than the standard recovery room stretcher litter top, and an overall height of 26 inches to permit patients to get on the stretcher without use of a stool, are features of the new Labor-OB room stretcher. It is designed for use in the labor room and for transferring patients from the labor to the delivery room. Dual control on all four casters permits locking the stretcher into

immobility when necessary. Standard equipment includes stirrup pockets at the foot end of the stretcher, standard side and end rails and an intravenous pole. **Jarvis & Jarvis, Inc., Palmer, Mass.**

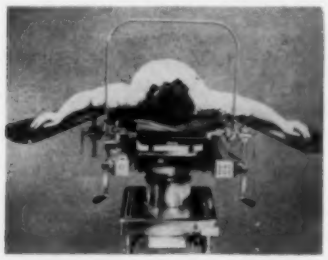
For more details circle #668 on mailing card.

(Continued on page 178)

WHAT'S NEW

Surg-A-Matic Operating Table Has Push Button Controls

A push button selection panel located at the end of the right control arm permits



quick and easy adjustment of the new Surg-A-Matic operating table. All controls are located at the head end of the table and adjustments to the desired operative positions are easily and quickly made by the operator without invading the sterile area or diverting attention from the patient. The kidney elevator is controlled from the right hand wheel, eliminating the necessity for a third control handle.

The new Surg-A-Matic also features table height adjustments from 27 to 45 inches, a maximum flex position of 139 degrees and a single adjustment proctoscopic position. Two types of hydraulic bases are available; motorized and non-motorized, the latter foot pedal operated. The smoothly designed base has no obstructions, simplifying maintenance. **Shampaine Co., 1920 S. Jefferson, St. Louis 4, Mo.**

For more details circle #669 on mailing card.

Modern Styling for Simoniz Bulk Containers

Institutional sized containers of Simoniz maintenance products have been redesigned. A polyethylene tamperproof spout is used as the improved closure. The new label incorporates the product name within the bold stylized "S" used by the company. The Simoniz "Professional Quality Seal" is also featured on the label to indicate the high performance rating of the various products in the heavy duty maintenance line manufactured by the company. **Simoniz Co., Commercial Products Div., 2100 Indiana Ave., Chicago 16.**

For more details circle #670 on mailing card.

Dry-Type Transformers Are Quiet, Light and Small

The new Westinghouse Type EP specialty transformers are quiet, light and small and are designed for application in commercial installations including schools, hospitals and offices. The dry-type transformers have core and coils completely encapsulated in resin with filler, providing a sealed unit that can be installed in hazardous areas. The excellent heat transfer properties of the resin and filler have made possible units considerably smaller and lighter than previous designs. The new transformers are available in ratings from ¼ to 10 kva, 600 volts and below, and can be mounted in any position on wall, floor or ceiling. **Westinghouse Electric Corp., P.O. Box 2099, Pittsburgh 30, Pa.**

For more details circle #671 on mailing card.

Hemoglobin Quickly Measured with Fisher Hemophotometer

The new Fisher Hemophotometer gives accurate measurement of hemoglobin direct and quickly. There are no calculations to make with the direct-reading unit which employs the accurate Drabkin method. The blood sample is diluted with Drabkin's solution, placed in a cuvet which is placed in the well of the Hemophotometer, and the technician reads the hemoglobin content immediately.

The new instrument is ruggedly constructed for easy, accurate use. A distilled water standard provided with the instrument permits quick checking of the zero point of the meter. When desired, the scale calibration may be verified with the reference facilities supplied. Any cuvet can be used in the instrument. The Hemo-

photometer has a white enameled metal housing, simple controls, and in operation the technician's right hand is free to note meter readings. **Fisher Scientific Co., 373 Fisher Bldg., Pittsburgh 19, Pa.**

For more details circle #672 on mailing card.

Built-In Booster Heaters for Jackson Dishwashers

Two new models of Jackson commercial dishwashers feature built-in booster heaters as an integral part of the machines. Requiring no additional floor space, the built-in boosters save on installation expense and convert 140 degree F. water to 180 degrees F. at maximum operation speeds.

The Model 50 APR-B illustrated has a capacity of 1400 dishes per hour while

the Model 10 A-B dishwasher washes, rinses and sanitizes 950 dishes or 1200 glasses at average operating speed. The stainless steel construction resists deterioration and the greatly increased wash jet pressure cuts soil from dishes at high speed. New, built-in vacuum breakers prevent back siphonage into water supply lines. **Jackson Products Co., 3703 E. 93rd St., Cleveland 5, Ohio.**

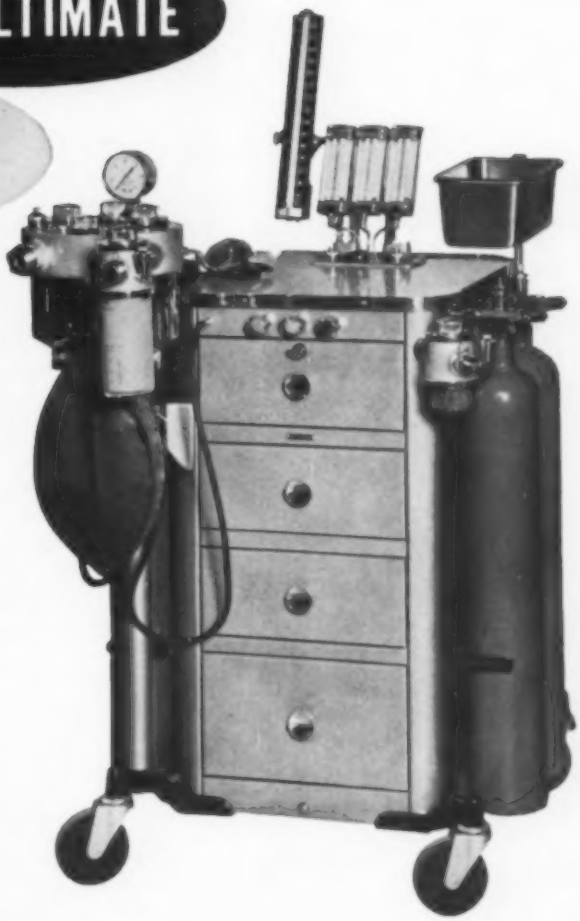
For more details circle #673 on mailing card.

(Continued on page 180)

THE ULTIMATE

in modern anesthesia equipment

NEW McKESSON CABINET MODEL



- Supplied with any combination of gases now in use.
- Equipped with bi-phase flow meters.
- Flow-rate controls mounted on front for utmost operating convenience.
- Twin Canister Absorber with 1800-gram baralyme capacity.
- Bag-Pressure Gauge shows pressure of gases in circuit at all times.
- Direct Oxygen Button for immediate oxygen under pressure.
- Direct Nitrous-Oxide Button for quick refilling of nitrous bag.
- Large storage capacity in four locking drawers.
- Stainless steel top and heavyweight steel construction.
- Finished in green enamel, trimmed with chrome-plated parts.
- Supplied with wide variety of accessories.

McKesson

NEW CABINET MODEL

For prices, other features and full details, write for McKesson Cabinet Model literature.

McKESSON APPLIANCE COMPANY • TOLEDO 10, OHIO

WHAT'S NEW

Sterilizing Tubing Has "Built-in" Indicator

The same hospital-tested, special ink formulation used on A.T.I. Steam-Clox and

steriLine Bags is used for the "built-in" indicator on the new A.T.I. steriLine paper tubing. It changes color from purple to green when proper sterilizing conditions of time, steam and temperature have been met and maintained. The tubing is designed for use in autoclaving catheters, syringes, pipettes and similar items.

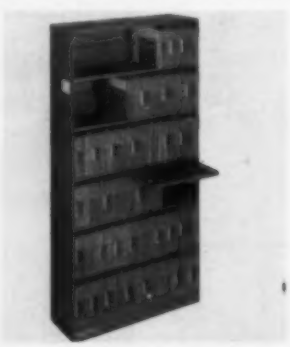
The new tubing is available in A.T.I. special wet-strength sterilizing paper or in Patapar paper, and has the added feature of one-inch markings to aid in cutting to any desired length. It is available in widths ranging from 1½ to three inches, in rolls 250 feet long. **Aseptic-Thermo Indicator Co., 11471 Vanowen St., North Hollywood, Calif.**

For more details circle #674 on mailing card.

"Add-A-Shelf" Feature on Open Shelf Files

Based on a modular concept, the new Diebold Open Shelf Filing System offers the "Add-A-Shelf" feature for expansion of filing space as needed. A unique interlocking system permits adding filing space side-to-side, top-to-bottom or back-to-back. Individual units lock together quickly and securely for solidity and rigidity. No tools are required to assemble the Open Shelf Filing Units.

Both letter and legal file sizes are available in the new units which are economical

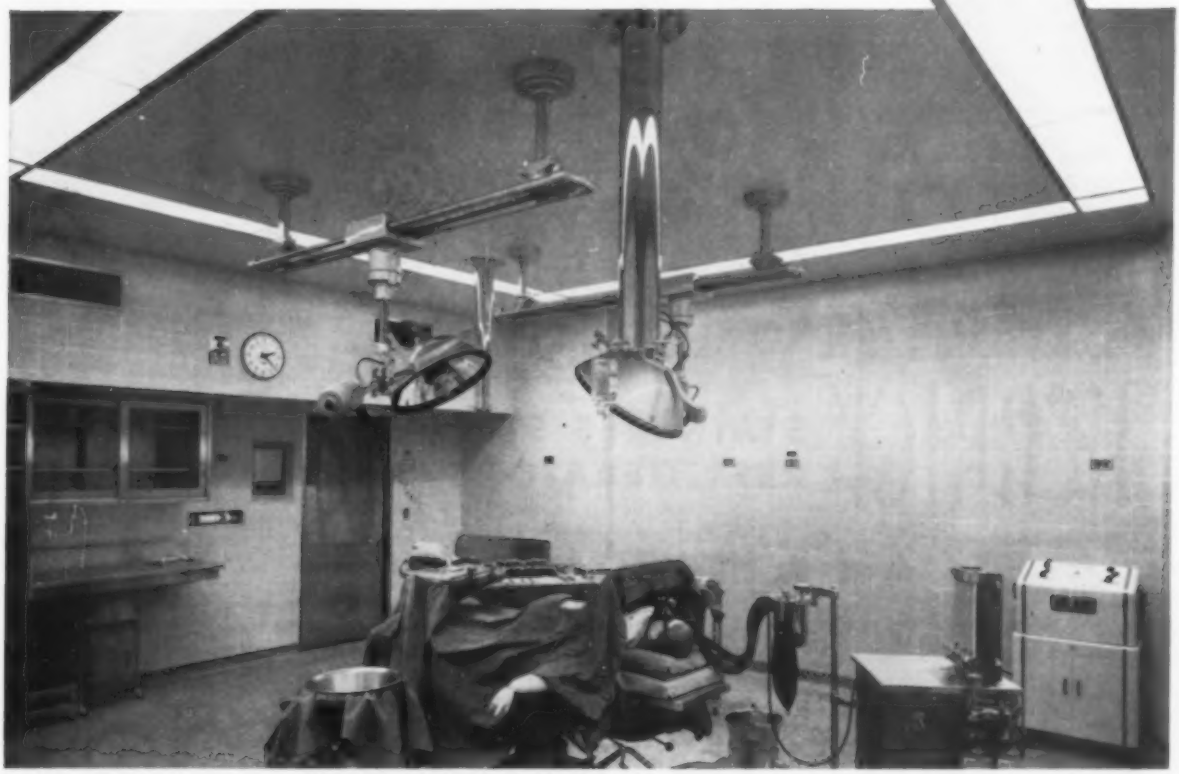


in cost and provide savings in space. Only 30 square feet of floor space are required to provide 2690 inches of filing space, and filing and finding take minimum time. Counter height installations can be capped to provide working area and higher installations can be used as room dividers. A Movable Folder Support in each unit holds folders upright. **Diebold, Incorporated, 818 Mulberry Rd., S.E., Canton 2, Ohio.**

For more details circle #675 on mailing card.

(Continued on page 182)

Full Circumference Lighting with DAY-BRITE Troffers and Accent Units



DAY-BRITE TROFFERS and Incandescent ACCENT UNITS provide high-level, over-all illumination in the new operating rooms of Children's Hospital, San Francisco. STONE, MULLOY, MARRACCINI & PATTERSON, *Architects;* BUONACCORSI & MURRAY, *Consulting Engineers;* CENTRAL ELECTRIC CO., INC., *Electrical Contractors.*

Ceiling mounted equipment, structural limitations and critical visual tasks can combine to create unusual problems in hospital lighting. The Day-Brite Recessed Troffers shown above are shallower, lighter and stronger . . . permit flexibility of installation necessary for a lighting system truly adapted to function.

Get the full facts on how versatile Day-Brite fixtures meet your specific requirements. Call your Day-Brite representative, listed in the Yellow Pages. Or write Day-Brite for illustrated booklet on hospital lighting.

Z-313

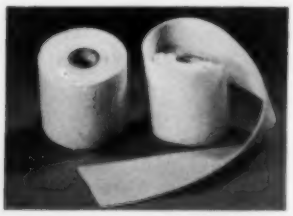
DECIDEDLY BETTER
DAY-BRITE
LIGHTING FIXTURES

Day-Brite Lighting, Inc., 6280 N. Broadway, St. Louis 15, Mo.
Day-Brite Lighting, Inc., of California, 530 Martin Ave., Santa Clara, California

NATION'S LARGEST MANUFACTURER OF COMMERCIAL AND INDUSTRIAL LIGHTING EQUIPMENT

WHAT'S NEW

Orthopedic Padding of Polyurethane Foam



Flex-O-Cel Elastic Polyurethane Foam is a new orthopedic padding which withstands autoclaving, cold, and flame and is perpetually elastic. It is supplied in bandage form in six-foot lengths in varying sizes for orthopedic use. The inert synthetic is odorless, non-toxic, non-allergenic and unaffected by bacteria, perspiration, urine, blood and similar materials. The interconnecting cellular sponge structure assures self-ventilation and patient comfort.

Flex-O-Cel Orthopedic Foam Padding is easily washable and in addition to its orthopedic uses on the patient, it can serve for table padding, x-ray positioning and insulation against heat and cold. **Medical Fabrics Co., Inc., 10 Mill St., Paterson 1, N.J.**

For more details circle #676 on mailing card.

Suspended-Type Cubi-Trac Now Interchangeable

The new suspended-type line of Cubi-Trac hospital cubicle tracks has an interchangeable feature, permitting use of the Cubi-Trac for both ceiling and suspended installation. Designed for use in patients' rooms, nursing homes, dressing rooms and other areas, the track is of aluminum construction, entirely enclosed except for the slot in the bottom, and in one continuous piece. All flanges and sockets are con-

structed of Tenzaloy, a durable aluminum alloy, for strength and light weight. **ADC Drapery Track Corp., 2121 S. 12th St., Allentown, Pa.**

For more details circle #677 on mailing card.

Space Saving Coat Rack Folds for Storage

The new VeeP folding hat and coat rack can be easily wheeled through doorways and corridors, yet opens to accommodate 72 coats and hats. The result of months of research and engineering, the new line of racks folds compactly for storage in minimum space. When opened they form a rigid rack 6½ feet long which is set up in seconds by lifting the arms which form the double hat or book shelves. The rack snaps open, locking itself in place, yet it is folded by a simple slip of the lock.

Strongly constructed of square tubular furniture steel, the rack has closed end

aluminum tubing shelves supported in cast aluminum brackets. Steel members are heavily plated and the aluminum tubing is anodized for attractive appearance and ease of maintenance. The new VeeP racks are available with rails for garment hangers or with anchor coat hooks suspended in staggered rows from the lower hat shelf. **Vogel-Peterson Co., 1127 W. 37th St., Chicago 9.**

For more details circle #678 on mailing card.

(Continued on page 184)

KEEP HOSPITAL RECORDS UNDER YOUR THUMB

BURROUGHS MICROFILMING

What a boon to your Medical Records librarian! With Burroughs microfilming, patients' medical records can be filed in a hurry, found in a wink, preserved with scrupulous care. For here is microfilming at its economical best—equipped to record and read, file and find, protect and preserve these truly vital statistics.

LOOK AT THESE SPECIFIC ADVANTAGES:

- Exclusive indexing meter locates any filmed document in seconds.
- With the Micro-Twin one compact unit controls both high-fidelity filming and high-clarity reading. Switch from recording to reading at the flick of a knob.
- Record storage space cut by as much as 99%.
- Low initial cost, followed by economies in time, space, clerical help.
- Facsimile prints of documents made quickly, easily. No refocusing, no darkroom required.

Find out what Burroughs microfilming can mean to your hospital. Phone our nearby office for details, or write Burroughs Division, Burroughs Corporation, Detroit 32, Michigan.

Bell & Howell / Burroughs

WHAT'S NEW

Microfilm Reader Has Ambidextrous Controls

The film winding wheel may be placed on either side of the viewing screen in

the new Medalist 16mm film reader. Placing it on the left side permits right handed people to take notes continuously if desired. All operating controls are within easy reach in front of the screen. They include the winding wheel for advancing the film; a scanning lever for centering film images; orientation wheel for turning film images upright; a focusing knob, and spindles for leading the film. The new gate-like type of aperture is self-loading. When the film starts moving, the aperture gate closes automatically and grasps the edges of the film, holding it in focus at all times.

Paper facsimile prints can be made with the Medalist without the need of a dark room. The Medalist reader offers a choice of three magnifications, one lens being supplied with the reader and the others available as accessories. The Recordak Medalist Reader is easily moved to place of need and occupies minimum desk space. **Recordak Corporation, 415 Madison Ave., New York 17.**

For more details circle #679 on mailing card.

Improved Design in Wardrobes and Casework

Several design improvements for quiet operation in every working area have been built into the line of Maysteel patient wardrobes and hospital casework. Drawers now move on silent self-lubricating bronze antifriction rollers and noiseless self-cleaning impregnated maple glides, eliminating squeaks, rattles and bearing noises. Door latches and drawer and door stops are cushioned in soft rubber and all doors are double-paneled and sound-deadened, making operating noises practically non-existent. **Maysteel Products, Inc., 740 N. Plankinton Ave., Milwaukee 3, Wis.**

For more details circle #680 on mailing card.

Human Skeleton Model of Unbreakable, Pliant Plastic

A human skeleton model is now available in articulated, unbreakable, pliant plastic. Twelve inches high, the model is suspended on a sturdy hanger with an eight-ounce non-tip base. It is easily removed from the container for close study. The base has a black background for better visibility of the skeleton, and a diagram on the reverse side identifies prominent bones. **Orthopedic Equipment Co., Bourbon, Ind.**

For more details circle #681 on mailing card.

Cleaning Time Saved With Wastebasket Scrubber

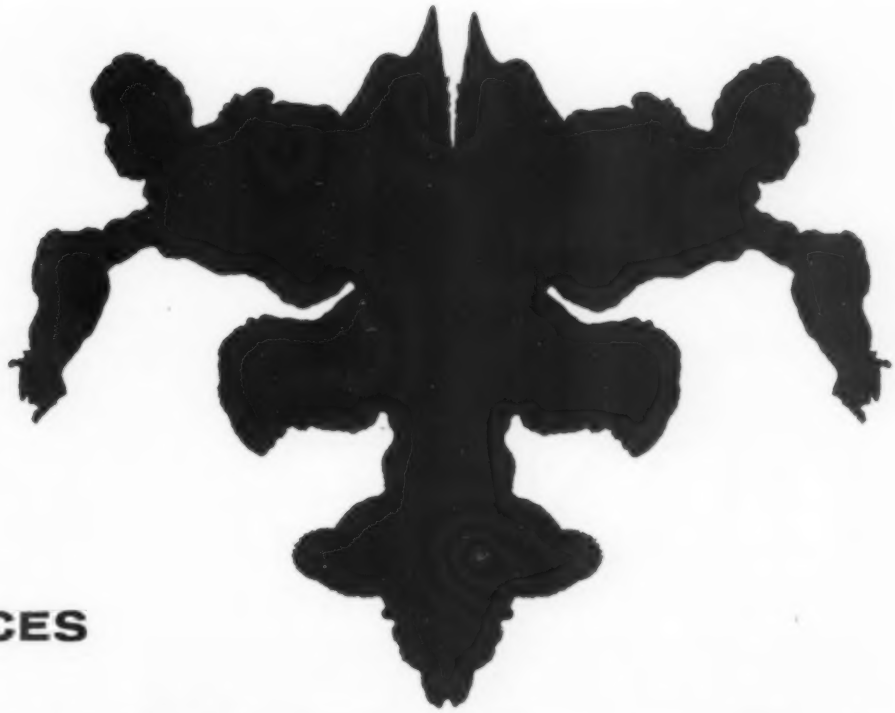
A motordriven machine is now available for scrubbing wastebaskets. Hours of cleaning time can be saved by using the new machine while life of wastebaskets is prolonged. The unit is designed for mounting on a bench top at waist height. Baskets are simply placed over a rotating brush which thoroughly cleans them and scrubs

out gummy substances, ashes and sticky residue.

The brush is composed of eight nylon brush strips which rotate at the rate of 200 revolutions per hour. Brush strips can be made to suit the size of all circular wastebaskets and each brush is engineered to the user's needs. **The Fuller Brush Co., Machine Div., Hartford 15, Conn.**

For more details circle #682 on mailing card.

(Continued on page 186)



SQUIBB

ANNOUNCES

VESPRIN

Squibb Triflupromazine

a new, improved agent for better management of the psychotic patient

Makes possible better custodial care by:

- moderating combative tendencies
- effecting *minimal* sedation, thus permitting better cooperation

Hastens social rehabilitation by:

- facilitating insight into reality
- increasing accessibility for psychotherapy

Improves patient-personnel relationship by:

- diminishing patient destructiveness
- bettering ward behavior

Chemically, pharmacologically and clinically improved, VESPRIN rapidly controls psychotic symptoms *without* oversedating the patient into sleepiness, apathy or lethargy. With VESPRIN, drug-induced agitation is minimal.

and in extensive clinical trial, VESPRIN has proved singularly free from toxicity

- jaundice or liver damage—not observed
- skin eruptions—rare
- photosensitivity—rare
- blood dyscrasias—not observed
- hyperthermia—rare
- convulsions—not observed

SQUIBB *Squibb Quality—The Priceless Ingredient*

"VESPRIN" IS A SQUIBB TRADEMARK

Sipco Cigarette Container for Wall Mounting

The new Model 4J Sipco cigarette container is designed to be permanently mounted on walls, posts, columns and other public areas for disposition of cigar and cigarette stubs. Both canister and supporting bracket are permanently installed to prevent pilfering. Cleaning is solved through the rugged, lightweight molded glass fiber inner unit which lines the heavy duty cast aluminum Jumbo canister. When the canister is partly filled with water, cigars and cigarettes dropped through the large hole in the canister lid go out at once, without smoldering and smelling. The new Model 4J is available in either Deluxe polished finish, standard black crinkle finish or in any color specified. Three message decals are available for the side of the container, or it can be ordered "less decals." **Standard Industrial Products Co., 920 N. Garfield Ave., Peoria, Ill.**

For more details circle #683 on mailing card.

Incubator Nebulizer Attaches Outside Patient Area

The Mist O_2 Gen All Incubator Nebulizer, Model MG 11 CX is designed to attach directly to Isolette incubators and has a universal adapter plate for attachment to Armstrong and all other incubators The new design allows attachment outside the patient area for ease of handling and simplified nursing care. The positive-holding metal lips attach to either plastic or metal inport holes.

The new unit is a large capacity nebulizer producing a visible fog of therapeutically effective particles. Instruction for operation and maintenance of the nebulizer is reduced to a minumum. Incubator atmosphere is circulated and recirculated through twin ports and oxygen may be diluted to 40 per cent when desired. **Mist O_2 Gen Equipment Co., 2711 Adeline St., Oakland 7, Calif.**

For more details circle #684 on mailing card.

Single Brush Floor Machine for Heavy Duty Cleaning

The Model E heavy duty floor machine has a 24-inch brush for cleaning large floor areas in schools, hospitals and other institutions. Interchangeable attachments adapt the Model E for scrubbing, waxing, polishing and buffing. It has an adjustable handle, momentary contact safety switch and non-marking bumper and handle grips. The new machine is also available with a three-gallon shower-feed tank on the handle for fast floor scrubbing. **Hild Floor Machine Co., Inc., 1217 W. Washington Blvd., Chicago 7.**

For more details circle #685 on mailing card.

(Continued on page 188)

MEET THE NEW HOLCOMB "BABY"...
Born to cut your waxing costs in half!

It's SIGNET—an amazing new floor wax developed by Holcomb Research that gives you—

1. **Positive anti-slip**
2. **Rich, beautiful gloss**
3. **Full water-proof protection**
4. **Longest wear ever**

And with SIGNET it's so easy to keep your floors beautiful all the time, regardless of traffic. It's tough, resists scuffing—doesn't hold dirt, buffs-up easily and wears like iron.

We guarantee SIGNET to save you money—give you safer, longer lasting floor protection. Ask your Holcombman for a free demonstration, or write

HOLCOMB SCIENTIFIC CLEANING MATERIALS

J. I. HOLCOMB MFG. CO., INC. · 1601 BARTH AVENUE · INDIANAPOLIS, INDIANA
Hackensack · Dallas · Los Angeles · Toronto

WHAT'S NEW

Medical Teaching Slides in Micro Recorder Series

Several new sets of two by two-inch medical teaching slides have been added to the Micro X-Ray Recorder Collection Series. The new sets include series on Pediatrics and benign and malignant surgical lesions. The 35mm reproductions are made from original x-rays, photographs and charts and each series is complete with a key booklet. **Micro X-Ray Recorder, Inc., 3735 W. Lawrence Ave., Chicago 25.**

For more details circle #686 on mailing card.

Low Initial Cost in Movable Wall System

Many design refinements of advanced prefabricated wall systems are incorporated

into the new Hauserman low-cost movable wall system. Low initial cost is claimed as the feature of the new Type HP wall system which is of fireproof and sound-resistant steel and glass construction. It has full-flush panels with single line joints thus permitting complete reusability of all components if and when the wall is changed in design or if it is relocated.

The Type HP movable wall has fully-adjustable ceiling trim to compensate for ceiling level variations, adjustable door frame, narrow base with provision for concealed lay-in wiring, rock-wool insulated panels finished in permanent low-gloss baked enamel and a choice of floor-to-ceiling or partially glazed wall areas. **E. F. Hauserman Co., 2100 Keith Bldg., Cleveland 15, Ohio.**

For more details circle #687 on mailing card.

Automatic Control Package for Unit Ventilators

The new Barber-Colman Automatic Control Package is specifically designed for controlling combination hot and chilled water unit ventilators. Combining a dual element, unit-mounted room and discharge controller with an oil-submerged spring return motor operator and a change-over thermostat, the control package provides a precise control system for both room and discharge temperatures. Both assemblies are prewired and equipped with plug-in cables to facilitate easy installation of the complete control system.

The control change-over from heating to cooling is automatic with the new control package. The strap-on thermostat activates the unit ventilator control system according to the need and the spring return motor operator ensures positive closing of outdoor air damper on fan shutdown and maximum convection when required. Being mounted within the unit, the dual element thermostat is immune to tampering by unauthorized personnel and is protected from dirt problems and the problem of finding wall space for mounting. **Barber-Colman Co., Rockford, Ill.**

For more details circle #688 on mailing card.

Heavy Luminaire Hanger Simplifies Servicing

The Triplex Hanger is a new disconnecting and lowering hanger developed for use with high bay fluorescent, mercury and incandescent luminaires or clusters weighing from 60 to 120 pounds. Featuring a multiple-fall pulley system, the Triplex permits one unskilled workman to lower, relamp and clean, then reposition heavy lights within minutes. All work is accomplished at floor level with a "dead" fixture which also encourages regular, low-cost cleaning. The new hanger is available with a wide variety of specially designed supension assemblies to meet the requirements of diversified installations. **The Thompson Electric Co., P.O. Box 873-BA, Cleveland 22, Ohio.**

For more details circle #689 on mailing card.

Vacuum Mop Cleaning Facilitated With "Skyhook"

Krako Power Vacuum Mops for efficient cleaning of floors and walls are easily carried during maintenance operations. A new attachment, designated the "Skyhook," solves the problem of snagging the long electric cord necessary in carrying the cleaning unit while in use. With the "Skyhook" attachment, the cord is held up on a wall or ceiling hook, giving it the needed flexibility without danger of hooking it on furniture and other objects. Cleaning is thus simplified and speeded. **Krako Division of Toledo, 3128 Bellevue Rd., Toledo, Ohio.**

For more details circle #690 on mailing card.

(Continued on page 190)

Brighten their meals... and lighten your chores with Roylies tray mats

The bright spot in a patient's day should be when meals are served. You can be *sure* food looks most appealing by serving on crisp, cheerful Roylies and Roylprint Paper Place Mats. Even the fussiest patients like the idea of a fresh mat for each serving. It gives them the feeling of complete sanitation and cleanliness... eating utensils never touch the bare tray. Roylies and Roylprints help reduce clatter, too. Staff chores are lightened because you use them once, then they're discarded. Roylies and Roylprints fit trays perfectly... come in a wide selection of gay colors and designs... or, if you wish, a special design with your hospital name and motif (with a color to match your interior). Mail the coupon today for more information and samples. No obligation, of course.

Roylprint

STOCK AND CUSTOM DESIGN PRINTED PAPER PLACE MATS

Royal Lace Paper Works, Brooklyn 1, N.Y. *(Division of Eastern Corporation)*

Royal Lace Paper Works, Dep't. MH-6
Brooklyn 1, N.Y.

Please send information on Roylprint and Roylies Place Mats—at no obligation to us.

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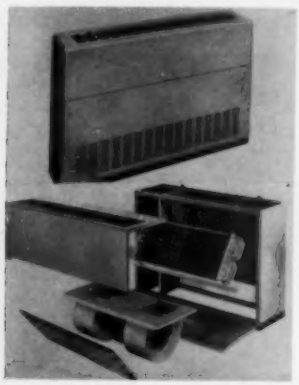
WHAT'S NEW

Versatile Line of Cabinet Heaters Redesigned in Style and Color

Attractive modern lines and a choice of seven colors are features of the redesigned line of American Blower cabinet heaters available in a broad range of hot water and steam ratings. The seven basic unit sizes



are each available in one-row and two-row heating elements suitable for steam or hot water, and a three-row hot water element.

The redesigned cabinet heaters are offered in two types, the blow-through and the draw-through. The blow-through designs are available with three-speed motors for extra quiet operation and low-speed drives can also be supplied for quiet operation. **American Blower, Div. of American-Standard, Detroit 32, Mich.**

For more details circle #691 on mailing card.

Pharmaceuticals

Dilcoron

Dilcoron is a new dual-action drug containing two vasodilators with demonstrated effectiveness on coronary vessels in the treatment of angina. The outer, sublingual layer of the tablet is glyceryl trinitrate 0.4 mg. which relieves pain immediately in an acute anginal attack. The tablet core consists of pentaerythritol tetranitrate 15.0 mg. for prolonged protection from attacks. A citrus-flavored lamina separates the two layers and is indication that the nitroglycerin action is completed and the tablet is ready to be swallowed. Dilcoron has produced satisfactory responses in acute and chronic coronary insufficiency, as well as enabling a reduction in the number of nitroglycerin tablets used. **Winthrop Laboratories, 1450 Broadway, New York 18.**

For more details circle #692 on mailing card.

Three Narcotics in Tubex System

Codeine phosphate, meperidine hydrochloride and morphine sulfate are now available in one cc doses in the Tubex line of closed-system medications for injections. The Tubex system provides an unbreakable and permanent metal syringe with disposable medication-containing cartridges. A sterile needle, protected by a guard, is affixed to each container. When the cartridge-needle unit is used, it is discarded. Cleaning and sterilization of equipment and syringe breakage are eliminated with the system which ensures accurate dosage. **Wyeth Laboratories, Radnor, Pa.**

For more details circle #693 on mailing card.

PMB-200

PMB-200 is the designation for a new potency "Premarin" with Meprobamate. It is indicated when unusual emotional stress complicates the menopause, providing extra relief from anxiety and tension with all the physical and mental benefits of "Premarin." PMB-200 contains 0.4 mg. "Premarin" and 200 mg. meprobamate. It is also available as PMB-400, containing 400 mg. meprobamate. Both strengths are supplied in bottles of 60 and 500. **Ayerst Laboratories, 22 E. 40th St., New York 16.**

For more details circle #694 on mailing card.

Tessalon

Tessalon is a new type cough control agent which acts on both the chest reflex and centrally in the medulla. It is indicated in all kinds of cough and is said to be particularly helpful in chronic chest diseases. Tessalon is non-habituating, non-addicting and non-constipating and acts rapidly with long lasting effect. It is supplied in bottles of 100 Perles. **Ciba Pharmaceutical Products Inc., Summit, N.J.**

For more details circle #695 on mailing card.

Paraflex Chlorzoxazone

Paraflex Chlorzoxazone is a skeletal muscle relaxant which acts by selective depression of multisynaptic reflex arcs in the spinal cord. It is indicated in the relief of painful muscle spasm in a wide variety of disorders. It is supplied in orange colored 250 mg. scored tablets in bottles of 50. **McNeil Laboratories, Inc., 2900 N. Seventeenth St., Philadelphia 32, Pa.**

For more details circle #696 on mailing card.

(Continued on page 192)

AMERICA'S SMARTEST BUYERS SPECIFY STEVENS FAMOUS BRAND SHEETS

Stevens is known for quality control and unsurpassed values in smoothness, extra whiteness, and durability and the Stevens exclusive Delta Finish®.

Stevens offers the widest selection—5 types to fit every purpose. They come in flat, fitted, bleached, colored regular hems, reversible hems, stamped identification, bonnazed, kaumagraphed.

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WHAT'S NEW

Literature and Services

• **Bulletin 611C,** dealing with water softening and conditioning equipment, is available from Elgin Softener Corp., 144 N. Grove Ave., Elgin, Ill. The 20-page booklet features automatic and manual zeolite water softeners as well as de-alkalizers which prevent corrosion of condensate lines and equipment, and de-ionizers that give the equivalent of distilled water at small cost.

For more details circle #697 on mailing card.

• Two booklets have been released by the Caterpillar Tractor Co., Peoria, Ill. **"Stand-by Power by Caterpillar"** is an eight-page booklet helpful in the selection of emergency power units. **"For Top Performance Specify Engine Power by Caterpillar,"** a 16-page booklet, explains how the reputation for highest quality diesel engines has been attained by this company.

For more details circle #698 on mailing card.

• **Deluxe Steel Shelving** is the subject of **Catalog No. 30** released by Deluxe Metal Furniture Co., Warren, Pa. The 64-page booklet, designed to assist users in selecting the proper shelving for all requirements, gives detailed suggestions. Divided into five sections, the catalog covers Deluxe boltless steel storage shelving, shop items, Deluxe Verti-File open shelf filing equipment, Deluxe library shelving and wardrobe cabinets.

For more details circle #699 on mailing card.

• **"Job-Fitted Attachments for Cleaning"** is the title of a six-page circular released by American Floor Machine Co., Toledo 3, Ohio. It is designed as an "encyclopedia" of vacuum attachments, giving definitions, uses, combinations and other factual data. It should prove helpful as reference material for the maintenance engineer.

For more details circle #700 on mailing card.

• **Catalog AD,** illustrating 250 anatomical diagrams used in charting patients' records, is now available from United Surgical Supplies Co., Inc., Port Chester, N.Y. The 20-page booklet uses line drawings to illustrate the diagrams, which are available as rubber stamps, pressure sensitive labels, paper charts and projection slides.

For more details circle #701 on mailing card.

• A pictorial brochure on the use of stone through the ages, from the time of the cave man to the present, is available from the Building Stone Institute, 420 Lexington Ave., New York 17. Entitled **"The Modern Stone Age Is Here,"** the booklet pictures every type of quarried stone in natural colors. It is designed for use by administrators, architects and building committees.

For more details circle #702 on mailing card.

• A new condensed catalog of **Powers Thermostatic Controls for Shower Baths, Hydrotherapy, Water Heaters, Heating, Ventilating and Air Conditioning Systems** is now available from the Powers Regulator Co., 3434 Oakton St., Skokie, Ill. Nine basic types of temperature and pressure controls are discussed in the 12-page booklet.

For more details circle #703 on mailing card.

(Continued on page 195)

WHAT'S NEW

• The problem of personnel who may be exposed to radioactive materials or to some form of x-radiation is discussed in a new 14-page technical **Booklet A-1009**a available from the Du Pont Company, Room N-2420-2, Wilmington 98, Del. Seven types of dosimeter films which form an integral part of the detection-protection problem are described, with data on useful exposure ranges and processing and calibration. A bibliography on dosimeter film usage is included.

For more details circle #704 on mailing card.

• **A 49-page illustrated revised catalog** of floor machines is offered by the Kent Co., Inc., Rome, N.Y. Kent's nine "Offset Machines," the Viking and Lightning vacuum machines, suction cleaners for furnace and boiler flue cleaning, a large selection of attachments and miscellaneous tools and four models of the "Turbo-Vac" line are listed.

For more details circle #705 on mailing card.

• **Catalog GEC-1032B** covers the subject of low-voltage distribution equipment and components available from the Distribution Unit, General Electric Co., Plainville, Conn. The 144-page **1958 General Catalog**, issued jointly by the Circuit Protective Devices and Distribution Assemblies Departments of the company, provides condensed information on all products of the two departments.

For more details circle #706 on mailing card.

• The new line of **"Klenzade Sanitation Brushes"** for use in food service is presented in a catalog published by Klenzade Products, Inc., Beloit, Wis. Information on the brush line, which features designs and materials new to the food service field, is presented. Each brush is designed for a particular cleaning task to save time and labor. They incorporate such materials as the new "sponge action" filled nylon material which holds increased amounts of cleaning solution, and the new "Bi-Nu" special composition block which is impervious to chipping, splitting and to cleaning chemicals and hot water. Brushes for vats and kettles, drain valves, pots and pans, small orifices and other food service needs are included in the new line.

For more details circle #707 on mailing card.

• A line of extremely shallow surface mounted luminaires, less than three inches deep, is described in the eight-page two-color **Bulletin O** published by Pittsburgh Reflector Co., 476 Oliver Bldg., Pittsburgh 22, Pa. Two types of luminaires are described, the Cleveland and The Shallowline. Also provided are full details, dimensional and engineering data.

For more details circle #708 on mailing card.

Supplier's News

Ohio Chemical & Surgical Co., 1400 E. Washington Ave., Madison 10, Wis., manufacturer of medical gases and related products, announces the opening of two new gas manufacturing plants at **Cleveland, Ohio.** The plants will manufacture cyclopropane and nitrous oxide. Both plants are unique in that all equipment was custom designed and an unusually high degree of instrumentation has been incorporated into the manufacturing process with greater storage capacity and transportation facilities.

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The two cards below are detachable and are addressed to us. With this flap folded out you can turn through the magazine for the items on which you want further information.

When, in either an advertisement or "What's New" you locate the product, turn to the index to advertisements on the following page or to the index of "What's New" items (left) where you will find the key number for the item. Items advertised are listed alphabetically by manufacturer. "What's New" items are in Key Number order. Circle the corresponding key number on the card below for each item in which you are interested. The second card is for the use of someone else who may also want product data.

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